



 **ARKANSAS HEALTHY CHILDREN**
HANDBOOK
6TH EDITION • 2012



Division of Child Care and Early Childhood Education

Health and Nutrition Unit

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ARKANSAS HEALTHY CHILDREN HANDBOOK

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Arkansas Department of Human Services



Division of Child Care and Early Childhood Education Health and Nutrition Unit

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Dr. Joycelyn Elders, former director of the Arkansas Department of Health as well as United States Surgeon General was in Lincoln, Nebraska, in 1992 when she came across a Healthy Children's Handbook. She thought that Arkansas' child care providers would appreciate being given the same kind of information.

Past editions of the Arkansas Healthy Children's Handbook were coordinated and produced by the Child & Adolescent Health Team at the Arkansas Department of Health with funding provided by the Arkansas Department of Health and the Arkansas Department of Human Services' Division of Child Care and Early Childhood Education.

This 2012 version has been coordinated and produced by the Arkansas Department of Human Services' Division of Child Care and Early Childhood Education, Health and Nutrition Unit with funding provided by the Arkansas Early Childhood Comprehensive Systems Initiative Grant. The information provided within this handbook should be considered the most current and up-to-date information and will be useful in making health-based decisions and developing your agency or program policies. It is the Health and Nutrition Unit's intention to keep this handbook revised and updated as soon as new health or medical guidelines suggestions are made. It is for that reason that this handbook has no permanent binding. We suggest that the handbook be placed in a three-ring binder. This way it will be easy to insert updates and changes and discard outdated pages.

As child care providers and educators, you are the front line in protecting and promoting the health of our children. It is our desire that this handbook will serve as a tool in helping you and your staff protect and promote the health and safety of Arkansas children.

Every Child Matters!

Buster Lackey, PhD
Health and Nutrition
Program Administrator
Arkansas Department of Human Services
Division of Child Care and Early Childhood Education

Note: While several Arkansas agencies and medical doctors provided information for this handbook, some of the material in this handbook is excerpted from a similar handbook produced by the Lincoln-Lancaster County Health Department in Nebraska. The state of Nebraska has graciously permitted Arkansas to adapt the book to fit Arkansas Child Care and Early Childhood Education Regulations.

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SURGEON GENERAL, STATE OF ARKANSAS
JOSEPH W. THOMPSON, MD, MPH

Welcome to a very comprehensive guide to child health. I applaud your dedication in using this guide to improve the health of the children under your care.

You will find useful, important information throughout this guide, but I ask that you pay close attention to the section on nutrition and physical activity. With 33 percent of Arkansas children overweight or obese by the time they reach kindergarten, we must start early to reverse this deadly epidemic. Obesity is a top contributor to serious diseases like hypertension, diabetes, heart disease and others that rob Arkansas citizens of their ability to lead healthy, productive lives. It is one of the most dangerous health issues we face today.

At the simplest level, preventing obesity is about balancing the energy taken in through food and beverage with the energy expended through physical activity. Replace sugar-sweetened beverages with low fat milk or water. Provide well-balanced meals and healthy snacks in age-appropriate portions sizes as described in this guide. Reduce screen time and help children have fun with plenty of vigorous physical activity.

Because childhood obesity is so prevalent these days it is sometimes difficult for parents to recognize when a child's weight becomes unhealthy. Maintaining a consistent relationship with a medical home as described in Chapter One will allow your child's doctor to help you monitor your child's weight and general health, including making sure your child receives the shots needed to avoid illness.

Many researchers and health professionals agree that if we don't reverse the obesity epidemic, the current generation of young people could be the first in U.S. history to live sicker and die younger than their parents' generation. What you do today will help keep this from happening tomorrow.

Sincerely,

A handwritten signature in black ink that reads "Joe Thompson".

Joseph W. Thompson, MD, MPH
Arkansas Surgeon General
Director, Arkansas Center for Health Improvement





ARKANSAS HEALTHY CHILDREN HANDBOOK

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On behalf of the Arkansas Childhood Comprehensive System Initiative, the Medical Homework group would like to thank the following for generously giving of time and resources to make the Sixth Edition of the Arkansas Healthy Children Handbook (2012) a great success. Your commitment to helping keep Arkansas children healthy is sincerely appreciated.

Arkansas Children's Hospital
The University of Arkansas for Medical Sciences (UAMS)
Arkansas Department of Health
Arkansas Department of Education
Arkansas Advocates for Children and Families
Arkansas Commission on Child Abuse, Rape & Domestic Violence
Arkansas Chapter, American Academy of Pediatrics
Arkansas State Police
Arkansas Coalition for Obesity Prevention
Arkansas Department of Human Services
 Division of Child Care and Early Childhood Education
 Health and Nutrition Unit
 Licensing Unit
 Division of Developmental Disabilities Services
 Division of Medical Services
 Division of Behavioral Health

Best Wishes,
Maya L. Lopez, MD
Buster Lackey, PhD
Arkansas Early Childhood Comprehensive System Initiative
Medical Home Workgroup CoChair



The Arkansas Healthy Children logo represents the intersection of four components of wellness: healthcare, nutrition, physical activity and safety. The logo also suggests a relationship with good health with a subtle reference to the symbol of first aid.



Division of Child Care and Early Childhood Education



ARKANSAS HEALTHY CHILDREN HANDBOOK

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Chapter 1 **Medical Home**

Chapter Content

What is a medical home?

Why should you have a medical home?

When should you go to the doctor?

What is “well-child care”?

What should I do for help when the doctor’s office is closed?

How to pick a medical home

To find out more

Recommendations for Preventive Pediatric Health Care (Periodicity Schedule)



ARKANSAS DEPARTMENT OF
HUMAN SERVICES



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ARKANSAS HEALTHY CHILDREN HANDBOOK

Chapter 1 **Medical Home**

WHAT IS A MEDICAL HOME?

It may sound like a building, but a medical home isn't an actual place. It's a doctor you or your child goes to for checkups or when you get sick. This doctor is called a "primary care physician," or PCP.

WHY SHOULD YOU HAVE A MEDICAL HOME?

It may seem easier to see any doctor you can when you or your child is sick. But having a medical home – one doctor or clinic you call every time – means you are more likely to get the best care possible. If you see the same doctor every time, that doctor will know what sicknesses and health care you have had. You and the doctor will also get to know each other.



WHEN SHOULD YOU GO TO THE DOCTOR?

If something is wrong with your health or your child's health, you should see your doctor. Health problems are easier to treat or manage when they are new. You should also see your doctor for checkups. Your doctor should know what problems to check for and what shots or medicines you need to stay healthy.

WHAT IS "WELL-CHILD CARE"?

Medicaid and most other insurance programs pay for children to see the doctor even when they're not sick. At these visits, the doctor will make sure your child gets all the immunizations he or she needs. These shots protect your child from sicknesses such as measles, tetanus and chicken pox. The doctor will also check for health problems and make sure your child is growing and developing as expected. If problems are found early, they are easier to treat or manage.

WHAT SHOULD I DO FOR HELP WHEN MY DOCTOR'S OFFICE IS CLOSED?

Most doctors have a number you can call after hours or on weekends or holidays. If you feel like you need to get care for a health problem that is not life-threatening, call your doctor first. Your doctor can tell you if you need care right away, or if you can wait until the clinic opens again.

HOW TO PICK A MEDICAL HOME

- The doctor and nurse believe that you know the most about your child.
- You are as important as the doctor and nurse when it comes to your child's health.
- You respect and trust the doctor, and the doctor respects and trusts you.
- The doctor respects your culture and beliefs. If you want a certain kind of treatment or care, the doctor agrees if he or she can.
- Your doctor asks you about what your child needs and works with you and others to meet those needs.
- Your child gets his or her shots, checkups and urgent care.
- Someone at your doctor's office helps you if your child needs a specialist or other services.
- The doctor makes sure everyone who helps take care of your child has the information they need.
- The people at your doctor's office help you if your child gets sick or has a special need. They help you learn about the problem and may help you find other resources.
- The doctor makes sure you know what your choices are when your child needs treatment.

TO FIND OUT MORE:

ConnectCare (ARKids First and Medicaid)
800-275-1131

www.arbetterbeginnings.com
Division of Child Care and Early Childhood Education/Better Beginnings
800-445-3316

The Patient-Centered Medical Home in Arkansas is an approach to providing comprehensive primary care for children, youth and adults. The Patient-Centered Medical Home in Arkansas is a health care setting that facilitates partnerships between individual patients and their personal physicians and, when appropriate, the patient's family.

– American Academy of Pediatrics (AAP) and American Academy of Family Physicians (AAFP)

This material was prepared by the Arkansas Foundation for Medical Care, Inc. (AFMC) under contract with the Arkansas Department of Human Services, Division of Medical Services. The contents presented do not necessarily reflect Arkansas DHS policy. The Arkansas Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act. MB2-MH-BRO,1-2/10



ARKANSAS HEALTHY CHILDREN HANDBOOK

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**ARKANSAS DEPARTMENT OF
HUMAN SERVICES**



Division of Child Care and Early Childhood Education

Chapter 2 Child Growth and Development



The following information describes normal growth and development and ways to encourage development in children. It is helpful to know about normal child growth and development so that you can:

- Create a safe and stimulating environment for children.
- Recognize children who are not developing as they should.

Growth refers to the body getting larger in size and **development** to the body becoming more skilled or mature.

The two main factors that affect children's growth (height and weight) are:

- **Parents** – Children inherit growth characteristics. For example, tall parents tend to have taller children, and short parents have shorter children.
- **Environment** (living conditions) – The most important environmental factor affecting growth is good nutrition (eating a balanced diet).

Development occurs in the following areas: (aligned with Bright Futures)

- **Gross motor skills** – the overall tone, strength and coordination of a child; how well a child is able to roll, sit and walk.
- **Fine motor skills** – hand-eye coordination and the ability of a child to grab and release small objects.
- **Cognitive, linguistic and communication skills** – how a child receives the information, thinks and expresses it.
- **Social and emotional skills** – how a child learns to see himself/herself as a loved, loving, able, unique human being, and how a child knows what is expected and how to act in his/her culture or society.

Since rates of growth and development vary in each child, use the following information as a general guide. If you think a child is not growing or developing as he/she should, discuss your concerns with the parents.

Physical Growth

HEIGHT AND WEIGHT IN INFANCY (BIRTH – ONE YEAR)

Babies, like adults, vary in size and shape. Although babies can vary a lot in their growth and still be healthy, watching growth is a way for you to see if they are getting good nutrition (enough to eat) and have adequate sustenance to support the processes of development.

The following heights and weights are general guides (averages):

- The average weight at birth varies from 6 to 9 pounds.
- The average length at birth varies from 18 to 22 inches.
- Babies gain 4 - 5 ounces a week (1½ pounds a month) from birth to 6 months, doubling their birth weight by 5 months (for example: 7 pounds at birth = 14 pounds at 5 months).
- They gain 3 - 4 ounces a week from 6 months to 1 year, tripling their birth weight by 1 year (7 pounds at birth = 21 pounds at 1 year).
- By their first birthday, babies have increased their birth length by half of their birth length. A baby 20 inches at birth will be about 30 inches at 1 year.

HEIGHT AND WEIGHT (BIRTH TO PRESCHOOL YEARS)

Growth slows down by the end of the first year. Preschool years are a time of slow but steady growth for children. During their second year (from age 1 - 2), children gain about 5 - 6 pounds. From 2 to 5 years, they gain about 4 - 5 pounds a year. Generally children's height at 2 years will be half of their adult height. (See the growth chart below.)

AVERAGE WEIGHT		AVERAGE HEIGHT	
BIRTH	7 pounds	Birth	20 inches
5 MONTHS	Double birth weight		
1 YEAR	Triple birth weight	1 YEAR	Add half of birth height
2 YEARS	Gain 5 - 6 pounds/year	2 YEARS	Half of adult height
2-5 YEARS	Gain 4 - 5 pounds/year		

Development

WAYS TO ENCOURAGE DEVELOPMENT (BIRTH - 3 MONTHS)

Muscle Skills

- Place infants in different positions when awake.
- Put on stomach and place brightly colored toys 8 - 10 inches in front of face, or make soft noises in front of head to encourage lifting of head.
- Hold infant in a sitting position, being sure back and head are supported. Put infant in infant seat. Do not place seats on counters, tables or chairs unless an adult stays nearby.
- Place brightly colored mobiles and pictures around infant's area.

Language Skills

- Talk to infant as much as possible when changing diapers, feeding and playing. Talk, then wait, giving infant time to respond.
- Respond to infant's laughs, coos and sounds with pleasure. Be expressive!

Social and Emotional Skills

- **Provide the child with the same caregiver as much as possible.** Infants bond well to only a few people. This bonding is critically important to developing feelings of trust and security.
- Be aware of baby's moods. Babies, like adults, like to play and eat when they are awake and alert. When infants are sleepy or fussy, they do not like eating or being handled.
- Don't worry about spoiling infants at this age – they need lots of love and attention.
- When an infant cries, check to see if he or she is hungry, wet, too cold or hot, or uncomfortable. If so, take care of that. If still fussy, try the following ways to comfort:
 - » Let baby bring hand to mouth – some babies quiet by sucking on their hands or fingers.
 - » Bring your face into baby's vision (8 - 10 inches from his/her face).
 - » Talk to infant in a soft, steady voice.
 - » If these measures don't work after about two minutes, pick up baby, swaddle (wrap snugly with a blanket), and hold close or rock or walk; this gives a feeling of closeness and warmth.



Chapter 2 **Child Growth and Development**

- Use pacifier if parents approve. (If using a pacifier, never leave it on a cord around the baby's neck; it can strangle baby.) Do not sweeten pacifiers.
- Provide quiet time when baby is not overstimulated.
- Pay close attention when you feed baby. Feeding can be the most important social and learning time for an infant.
- Spend lots of time holding each baby and looking at him/her. Your face and smile are very important to baby.

DEVELOPMENTAL TASKS (BIRTH - 3 MONTHS)

Muscle Skills

- Moves arms and legs equally well.
- When on stomach, ability to raise and control head improves.
- When on back, eyes follow bright objects or person's face from side to side.
- Stares at objects held about 8 - 10 inches in front of him or her (likes human faces and bright colors best).
- Likes high contrast (black and white) and bright colors (oranges, reds and yellows).
- Slowly develops more head control when in sitting position.
- Movements not yet well coordinated; startles to loud sound or sudden change of position.
- Cannot yet control hands.

Language Skills

- Makes some noises other than crying (coos).
- Can hear well; likes human voice.

Social and Emotional Skills

- Comforts when talked to, held and cuddled.
- Sucking brings comfort.
- Crying usually means: hunger, loneliness, wet, cold, hot or other discomfort.
- Cries to let you know needs – calms down when needs are met (food, dryness, warmth and loving).
- Trust begins to be developed when you respond to baby's needs. Baby in turn quiets, looks with eyes.
- Smiles responsively by 2 months.

WAYS TO ENCOURAGE DEVELOPMENT (3 - 6 MONTHS)

Muscle Skills

- Provide lots of time for sitting up (support head and back until good head control is complete).
- Have brightly colored toys within reach; use toys that baby can hold with hands.
- Give toys with different textures (soft/rough).

Language Skills

- Speak or sing to baby; use *adult talk*, not *baby talk*.
- Use expressive language (happy voice, laughter, etc.).
- Respond to baby's coos and babbles with similar sounds.



Social and Emotional Skills

- Have the same person care for the same babies as much as possible; this helps them learn to trust and develop relationships with others.
- Babies in this age group are very social beings.
- Cry begins to be different for hunger, discomfort, wanting attention, etc. Baby still needs attention when he cries – you can't spoil him/her.

Thinking Skills

- Provide interesting toys such as:
 - » Toys that make noise, rattles, squeeze toys stuffed animals with noisemakers inside.
 - » Toys that can be reached for and held, crib gym, soft toy above crib to kick.
- Provide time for being near other infants and adults.

NOTE: Babies at this age put objects in their mouths. Check all toys to be sure they do not have small pieces that babies can choke on or swallow. If hanging toys over cribs, make sure they are high enough so the baby cannot pull them down and become strangled by the cord.

DEVELOPMENTAL TASKS (3 - 6 MONTHS)

Muscle Skills

- Gains more muscle control.
- Rolls over; begins to sit (first with support, gradually more on own). Head steady when put in sitting position.
- Reaches for object, holds object in hand and can bring hands together (like clapping); looks for object that goes out of sight.
- Vision improves; can see more clearly.
- By 3 - 6 months, transfers object from one hand to another.
- By 5 - 6 months, can find mouth with hands.
- By 3 - 7 months, bears some weight on legs.



Language Skills

- Makes a variety of sounds, coos and may begin babbling.
- Turns eyes in the direction of sound (especially voices).

Social and Emotional Skills

- Smiles.
- Makes eye contact.
- Shows signs of attachment to important caregiver(s) (father, mother or usual child care provider).
- Responds differently to different people.

Thinking Skills

- Responds to environment, laughs; looks at objects making sounds.
- Begins to explore body.

WAYS TO ENCOURAGE DEVELOPMENT (6 - 9 MONTHS)

Muscle Skills

- Provide a safe environment so infant can creep, crawl and explore.
- Have lots of toys of different shapes, textures and colors. Be sure toys are safe (no small pieces or sharp edges).
- Provide finger foods infant won't choke on. (Children progress on solid foods at different rates; start out with crackers and then move on to small foods.)
- Let infant begin feeding self. Try to use cup with small amounts of fluids.

Language Skills

- Talk to infant, use descriptive words to comment on infant's activities.
- Praise when infant makes sounds.
- Imitate sounds made by infant.
- Provide squeaky or musical toys.

Social and Emotional Skills

- Continue to provide the same caregiver as much as possible.
- Play games such as peekaboo, or making toys disappear and then immediately come back.
- Provide playtime with infant.

Thinking Skills

- Continue using toys suggested for 3 to 6-month-olds. Try rotating them so some new toys become available each week.
- As infant begins creeping or crawling, provide large, safe area to explore.

DEVELOPMENTAL TASKS (6 - 9 MONTHS)

Muscle Skills

- Sits alone without support, has good head control and may crawl.
- Able to get from lying to sitting (6 - 11 months).
- Can pull self to stand up, may take a step while holding on (6 - 10 months).
- Reaches out and grasps objects (rattles, toys).
- Looks for object that goes out of sight.
- Begins self-feeding with finger foods and cup.

Chapter 2 **Child Growth and Development**

Language Skills

- May say *dada* or *mama* but does not connect these words with specific people.
- Imitates speech sounds and noises.
- Turns and looks in the direction of sounds.
- Likes musical sounds, squeaky toys.

Social and Emotional Skills

- Begins to be shy or uneasy with strangers.
- May show strong preference or attachment to one or two people.
- Enjoys games like pat-a-cake or peekaboo or hiding a toy and then having it reappear.
- Smiles at self in the mirror.

Thinking Skills

- Spends much of daytime awake and alert.
- Recognizes familiar people and objects.
- Begins to develop memory.

WAYS TO ENCOURAGE DEVELOPMENT (9 - 12 MONTHS)

Muscle Skills

- Think about safety. As babies gain mobility, they get into lots of new areas.
- Provide a safe area with enough space for creeping and crawling.
- Let child pull self up to stand. A railing or low furniture can encourage “cruising.”
- Give toys such as: spoons, plastic containers and cups, balls, large blocks, and pots and pans.
- Play with a large soft ball – allow child to roll it, throw it, and catch it.
- Be sure toys cannot fit into baby’s mouth. Choking is a big risk at this age.
- Have outside playtime in a safe play area.

Language Skills

- Always take time to talk with child (while playing, bathing and changing diapers).
- Use *adult* talk, not *baby* talk.

- Make sounds the child can copy.
- Begin using simple commands and show child what your words mean (for example: “sit down” or “come here” and use hand gestures at the same time).

Social and Emotional Skills

- Continue to provide the same caregiver as much as possible.
- Play with child. Show how toys work; don’t just give toys.
- Talk, smile, laugh and have fun!

Thinking Skills

- Provide toys that are age-appropriate and challenge the child to learn (like in-and-out toys, push-pull toys, stacking cones, music boxes and jack-in-the-boxes).
- Teach child how toys work.
- Give child an opportunity to learn to do things for himself/herself, such as feed self.

DEVELOPMENTAL TASKS (9 - 12 MONTHS)

Muscle Skills

- Can get from lying down to sitting position; sits well alone.
- Creeps and crawls.
- Pulls self up to a standing position; may be able to stand alone and may take several steps while holding on.
- Can use thumb and fingers to grasp and hold objects.
- Holds cup and spoon.
- Has good hand-to-mouth coordination.



Language Skills

- Imitates sounds like clucking or lip smacking.
- Uses words such as *dada* and *mama*.
- May understand one or two simple commands.
- Begins to understand the word no!

Chapter 2 **Child Growth and Development**

Social and Emotional Skills

- May still show fear with strangers; attaches to main caregiver(s).
- Very responsive to adult's smiles, voice, eye contact and play.
- Recognizes self in the mirror.
- Begins to be interested in activities of others.

Thinking Skills

- Remembers toys and people.
- Curious about objects; likes to put things in and out of containers.
- Likes to pull a cover off a toy he or she has seen hidden.

WAYS TO ENCOURAGE DEVELOPMENT (1 - 2 YEARS)

Muscle Skills

- Have safe play area outdoors and indoors for using large muscles (running, climbing, throwing and jumping).
- Supervise coloring and painting.
- Provide good toys and games such as: blocks, toys to climb on, dress-up clothes, items to play house with, and colorful picture books.
- Can begin toilet training if child shows signs of readiness, such as:
 - » Complains of wet pants.
 - » Shows interest in toileting activities of others.
 - » Stays dry for several hours at a time during the day.



NOTE: Be aware that bladder and bowel control do not necessarily occur at the same time.

Language Skills

- Play sound games (a cow goes “moo”); play naming games (show me your “nose”).
- Sing and tell short rhymes.
- Encourage talking

Social and Emotional Skills

- Let children begin to play with each other – expect mostly individual play, but they do enjoy being near one another.
- Don't punish child if refusing to share.
- Whenever possible, give child choices so that he/she has an opportunity to exert control over situations (set your limits clearly before giving a child the choice).

Thinking Skills

- Provide picture books with large, bright pictures.
- Encourage children to draw murals and large paintings and tell stories about them.

DEVELOPMENTAL TASKS (1 - 2 YEARS)

Muscle Skills

- Skills getting better (walks, runs, climbs steadier and jumps).
- Stacks more blocks.
- Can copy a straight line.
- Kicks and throws a ball.
- May be able to pedal a tricycle.
- Gains more control over bladder and bowel movements.

Language Skills

- Begins to combine two words.
- Can name some parts of body (ears, eyes, etc.) or point to them appropriately.
- Can name pictures of common objects (cat, dog, man and house).
- Can follow simple one-step directions (*Bring the book to me*).
- Likes singing and rhymes.

Social and Emotional Skills

- Children play side by side not really interacting with each other – may do the same activity near others – no real concept of sharing.
- Begins to dress self – puts on simple clothing.
- Still likes to copy adults.
- Continues to develop independence – begins to say “no” when asked to do things or asked questions.

Chapter 2 **Child Growth and Development**

Thinking Skills

- Getting better at solving problems.
- Begins to play make-believe/pretend.

WAYS TO ENCOURAGE DEVELOPMENT (2 - 3 YEARS)

Muscle Skills

- Have safe play area outdoors and indoors for using large muscles (running, climbing, throwing and jumping).
- Allow tricycle riding supervised and in safe area. Begin the “helmet” habit. Have children wear bicycle helmet when riding to protect against head and brain injury.
- Supervise coloring and painting.
- Good toys and games are blocks, toys to climb on, dress-up clothes, items to play house with, and colorful picture books.
- Can begin toilet training.

Gross Motor Skills

- Play with balls.
- Allow toilet training to proceed at child’s pace.

Language Skills

- Singing
- Wordless books encourage children to tell the story. Adult listens, and adds details or pronounces correctly what child says.
- Read books aloud, at least one every day.
- Encourage children to recount everyday events and details.

Social and Emotional Skills

- Model social skills.
- Help child to use words to solve social problems.
- Ignore negative behavior whenever possible.
- Allow choices about many daily events.
- Encourage child to express feelings verbally.
- Play simple turn-taking games such as tag, musical chairs and Simon says.

Thinking Skills

- Simple puzzles.
- Books with interesting, age-appropriate stories.
- Art projects with many textures, colors; large paintings.

DEVELOPMENTAL TASKS (2 - 3 YEARS)

Muscle Skills

- Running and stopping, stepping up or squatting.
- Stands on one foot.
- Jumps in place with both feet.
- Rides tricycle (helmets are recommended).
- Throws ball overhand.
- Stacks more blocks, up to eight cubes, or builds bridges.

Language Skills

- Follows two-step directions (“Get the book, and put it on the table”).
- Names five to six body parts on himself/herself.
- Takes part in simple conversations.
- Answers simple questions.
- Uses two- to three-word sentences regularly.
- Uses plurals.
- Asks lots of questions.

Social and Emotional Skills

- Helps with simple tasks, such as picking up toys.
- Washes and dries hands.
- Dresses with supervision.
- Separates from mother easily.
- Plays interactive game (tag).
- Asserts individuality.
- May be negative or demanding.
- Likes rituals.
- Likes to feed himself (but still spills).



Chapter 2 **Child Growth and Development**

Thinking Skills

- Making choices.
- Establishing individuality.
- Beginning to grasp cause, and cause-and-effect relationships.

WAYS TO ENCOURAGE DEVELOPMENT (3 - 4 YEARS)

Muscle Skills

- Continue to allow toilet training to proceed at own pace.
- Allow for plenty of free play time out of doors.
- Provide with safe climbing structure and tricycles (helmets recommended).
- Allow for messy art play.

Language Skills

- Same as for two- to three-year olds.
- Answer questions straightforwardly and simply.
- Focus on topics of interest to the child to increase vocabulary.

Social and Emotional Skills

- Model social skills.
- Help child to use words to solve social problems.
- Ignore negative behavior whenever possible.
- Allow choices about many daily events.
- Encourage to express feelings verbally.
- Play simple turn-taking games such as tag or musical chairs.

Thinking Skills

- Practice counting.
- Allow child to make choices about activities.
- Encourage child to problem solve when possible.
- Develop classification skills by making collections of similar objects for children to sort and compare: buttons, small plastic objects, spools, lids, etc.

DEVELOPMENTAL TASKS (3 - 4 YEARS)

Muscle Skills

- Jumps, runs, throws, climbs, using good balance.
- Balances on one foot five seconds.
- Starts learning to catch.
- Walks tiptoe.
- Draws up, down, around and sideways using a crayon.
- May or may not be dry at nap time and nighttime.

Language Skills

- Uses plurals, past tense, pronouns and prepositions.
- Uses speech that is easily understood.
- Asks a lot of “why” and “what” questions.
- Answers simple “where” and “who” questions.
- May recognize colors.
- Gives first and last name.

Social and Emotional Skills

- Enjoys playing with other children.
- Waits his or her turn some of the time.
- Dresses partly, undresses completely.
- Can ask for help if he/she needs it.
- Engages in make-believe and “let’s pretend” games.
- Likes to learn and follow the rules.

Thinking Skills

- Has attention span of about 10 minutes.
- May know shapes.
- Still doesn’t understand idea of time.
- Can count objects.
- Learns to classify objects by color, form, size, etc.



WAYS TO ENCOURAGE DEVELOPMENT (4 - 5 YEARS)

Muscle Skills

- Continue to provide opportunities for plenty of large muscle activity.
- Reinforce progress in self-help skills (toileting and dress).
- Teach and model healthy habits (for example, hand washing, sanitary eating habits, and covering nose and mouth when coughing/sneezing).
- Encourage self-expression through creative activities, such as drawing, painting and dramatic play.
- Provide child-size scissors (left-handed, if needed) and larger size crayons.



Language Skills

- Teach child correct use of the telephone.
- Encourage child to tell stories, real and make-believe, and have child choose ending.
- Involve child in planning activities and sharing his/her events: holiday decorations, meal preparation and outings.
- Reinforce and encourage child's progress in speech skills: "I like the way you described your new dress."
- Read to child daily. Ask questions about events in the story.

Social and Emotional Skills

- Encourage healthy expression of feelings. Provide acceptable outlets for anger.
- Provide opportunities for role-playing through puppets, dress-up clothes.
- Avoid power struggles. Give clear, simple rules and consequences. Give only acceptable choices. Use such terms as "It's time to...," or "The rule is..."
- Encourage positive peer support by using the "buddy system" – pairing more outgoing child with shy child.
- Help identify and distinguish between real and imaginary fears.
- Model good table manners and common courtesy.

Thinking Skills

- Use calendars, clocks and other visual markers to teach time concepts: “When both hands are on the 12, it will be lunch time.”
- Reinforce staying with task.
- Provide simple, honest answers to their why, what, where questions.
- Continue to teach problem-solving skills through stories, games and actual situational opportunities.

DEVELOPMENTAL TASKS (4 - 5 YEARS)

Muscle Skills

- Hops on one foot; balances on one foot for 10 seconds.
- Climbs down steps, alternating feet.
- Toilets without help.
- Puts on clothing with some help; laces shoes but does not tie shoes.
- Draws three-part stick person.
- Cuts on line with scissors.

Language Skills

- Tells stories, mixes fact and fiction.
- Tries out silly words and sounds; trying “four-letter” words (curse words) is typical and should be dealt with calmly.
- Has vocabulary of near 1,500 words; sentence length of four to five words.
- Uses adjectives; uses past tense correctly.
- Understands common opposites (big/little; hot/cold).
- Uses these sounds correctly: m, n, ng, p, f, h, w, y, k, b, d, g and r.

Social and Emotional Skills

- Uses verbal skills instead of reacting physically (hitting or grabbing) most of the time.
- Verbally expresses anger, frustration or jealousy.
- May be bossy, call others names and brag about accomplishments.
- May have imaginary playmates and real worries and fears.
- Plays better in a group, shares and waits turn more easily than a younger child.
- Separates easily from parents or primary caregiver.



Chapter 2 **Child Growth and Development**

Thinking Skills

- Has longer attention span, stays with one activity at least 10 - 15 minutes.
- Understands some time concepts: noontime, early in the morning, next month and next year.
- Identifies crosses, triangles, circles and squares.
- Thinks of imaginary conditions such as, "What if" or "I hope that."
- Sometimes feels that his/her thoughts and wishes cause events to occur. May feel guilty when negative events happen.

WAYS TO ENCOURAGE DEVELOPMENT (5 - 6 YEARS)

Muscle Skills

- Provide adequate space for large muscle activities (e.g., throwing and catching balls).
- Provide ample materials for using small muscles (e.g., cutting, pasting, drawing and sewing).
- Encourage rhythm activities; provide simple musical instruments (e.g., drums and cymbals).
- Provide building and carpentry experiences.
- Encourage child's interest in printing letters, own name.

Language Skills

- Continue encouraging new vocabulary by reading longer stories and poetry. Define new words and concepts.
- Provide field trips to explore child's neighborhood (e.g., post office, fire station, library, etc.).
- Encourage use of reference books – help child look up answers to questions and special interests (e.g., dinosaurs or snakes).
- Listen to child. Give positive feedback verbally and nonverbally.

Social and Emotional Skills

- Give child message that he/she is loved and valued. ("I'm glad you're here today.")
- Reinforce cooperative group behaviors.
- Model appropriate coping skills and expression of feelings.



- Encourage responsibility for small chores.
- Provide opportunities for child to help younger or less skilled child.
- Provide clear rules and consequences.

Thinking Skills

- Play games that have a few clear directions (e.g., board games and checkers).
- Provide opportunity for simple science experiments (e.g., magnets, water to ice/steam).
- Present relevant problems or use actual situations to let children provide possible solutions.
- Provide variety of objects for counting games.

DEVELOPMENTAL TASKS (5 - 6 YEARS)

Muscle Skills

- Catches a bounced tennis ball two out of three tries; throws a ball well.
- Draws a six-part figure with more details.
- Sews with large needle and yarn or thread.
- Ties a bow.
- Walks backward and forward with heels and toes 1 inch apart in a straight line.
- Dances and marches to music.
- May ride bicycle instead of tricycle (reinforce use of bicycle helmet).



Language Skills

- Defines objects by their use (e.g., eat with fork or swim in lake).
- Tells what common objects are made of (e.g., door made of wood; spoon made of silver or plastic).
- Has vocabulary of around 2,000 words. Sentence length six-plus words.
- Uses all types of sentences, some complex (e.g., "I can go in the house after I take off my muddy shoes.").
- Uses most of the speech sounds correctly (possible exceptions: t, v, l, th, j, z and zh).

Chapter 2 **Child Growth and Development**

Social and Emotional Skills

- Has sense of humor; plans surprises and jokes.
- Prefers own age group for play; plays cooperatively; likes to conform.
- Expresses sympathy for others; protects younger children.
- Displays pride in abilities and possessions.
- Expresses thoughts and feelings through dramatic play with a variety of toys.
- Copies behavior of significant adults and peers.
- Begins to resolve conflicts considering the other child's feelings.

Thinking Skills

- Has longer attention span – more than 15 minutes. Remembers previous experiences better.
- Counts objects to 10: identifies nickels, dimes and pennies. Groups items according to shape, size, color and function.
- Follows three-step directions (e.g., “Get your coat; put it on; and then stand by the back door”).
- States full name, age and gender.
- Does more complex problem solving.
- Is interested in why and how things work.

SEXUAL DEVELOPMENT OF CHILDREN (BIRTH - 4 YEARS)

Physical

Babies are born with the ability to feel pleasure in their genitals and other erogenous zones. Boys' penises have erections, and girls' vaginas lubricate from birth. Babies will touch and play with their genitals, just as they do with everything else in the world.

Physical closeness is essential for babies and children. Infants cannot learn to speak unless spoken to and likewise cannot learn how to love and show affection unless they are hugged, tickled and kissed. This also helps build positive self-esteem. Physical affection with babies and young children is the foundation of healthy sexual development. Security objects and activities, such as imaginary friends, blankets, favorite toys and thumb sucking, are also normal and sources of comfort and affection for children.

Intellectual-Social-Emotional

By the time they begin to speak (18 months to 2 years), children know whether they are male or female. They learn the differences and similarities between genders.

SEXUAL DEVELOPMENT OF CHILDREN (5 - 9 YEARS)

Physical

Children of both sexes may experience sex play with other children, especially same-sex friends. It is important to remember that this play does not acquire sexual meaning until after puberty. Children may masturbate but learn to hide it if met with correction or disapproval.

Intellectual-Social-Emotional

Children begin to learn how to make and keep friends, and may go through a period of disliking opposite-sex children. They learn the concepts of public and private behavior. There is increased interest in pregnancy, childbirth and the family. Children experiment with “dirty” words and slang terms for information and sometimes for shock value.

SEX PLAY AMONG CHILDREN

Sex play among children is common and, like other play, is a normal expression of curiosity. Undressing, “playing doctor” and “playing house” are typical of preschool children. This helps children understand gender differences and is usually limited to peers, although young children may want to touch their parents’ sexual organs. It is important to remember that childhood sex play is primarily motivated by the “need to know,” and not (for young children) by sexual/erotic feelings.

If children exhibit frequent aggressive behavior, overt sex act behavior or seem preoccupied with sex over a period of time, particularly toward children significantly younger (a two-year difference), consult with your public health nurse or other health professional.

WAYS TO PROMOTE DENTAL HEALTH

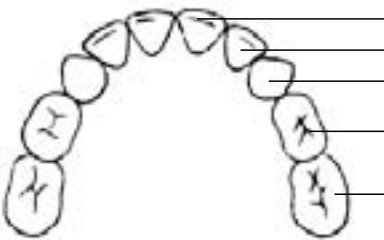
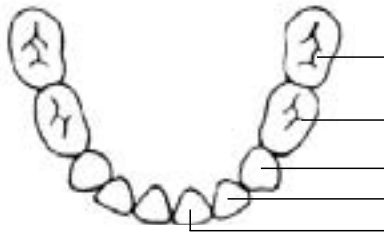
- Ask if all children have a dentist, particularly after the age of 1.
- Always hold an infant while feeding; never prop the bottle.
- Never allow an infant to fall asleep with a bottle that contains milk, formula, juice or any sweetened liquid.
- Avoid dipping a pacifier in any sweetened liquid.
- Encourage twice daily teeth brushing.



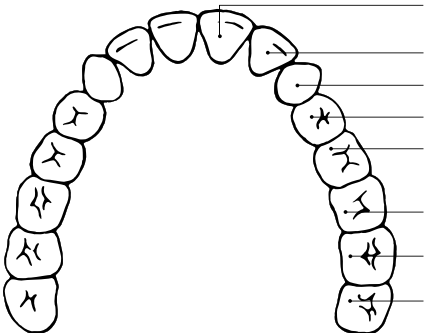
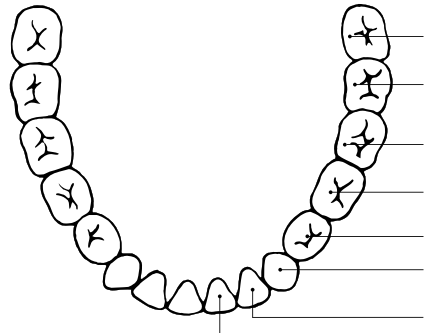
PRIMARY/PERMANENT TEETH ERUPTION CHART

Please note: When you look at the tooth chart, you are looking into a person's mouth with the jaws open. You're facing the person, so their upper right jaw will be on the left of this image.

Primary Teeth Eruption Chart

Upper Teeth		Erupt	Shed
	Central incisor	8-12 mos.	6-7 yrs.
	Lateral incisor	9-13 mos.	7-8 yrs.
	Canine (cuspid)	16-22 mos.	10-12 yrs.
	First molar	13-19 mos.	9-11 yrs.
	Second molar	25-33 mos.	10-12 yrs.
Lower Teeth		Erupt	Shed
	Second molar	23-31 mos.	10-12 yrs.
	First molar	14-18 mos.	9-11 yrs.
	Canine (cuspid)	17-23 mos.	9-12 yrs.
	Lateral incisor	10-16 mos.	7-8 yrs.
	Central incisor	6-10 mos.	6-7 yrs.

Permanent Teeth Eruption Chart

Upper Teeth		Erupt
	Central incisor	7-8 yrs.
	Lateral incisor	8-9 yrs.
	Canine (cuspid)	11-12 yrs.
	First premolar (first bicuspid)	10-11 yrs.
	Second premolar (second bicuspid)	10-12 yrs.
	First molar	6-7 yrs.
	Second molar	12-13 yrs.
	Third molar (wisdom tooth)	17-21 yrs.
	Second molar	11-13 yrs.
	First molar	6-7 yrs.
	Second premolar (second bicuspid)	11-12 yrs.
	First premolar (first bicuspid)	10-12 yrs.
	Canine (cuspid)	9-10 yrs.
	Lateral incisor	7-8 yrs.
	Central incisor	6-7 yrs.

Promoting Oral Health website: <http://www.healthychildren.org/English/healthy-living/oral-health/pages/Caring-for-a-Young-Childs-Teeth.aspx>

QUESTIONS AND ANSWERS FOR PROFESSIONALS ON INFANT SLEEPING POSITION AND SIDS

From <http://aappolicy.aappublications.org/cgi/content/full/pediatrics;116/5/1245> and <http://www.nichd.nih.gov/sids/sids.cfm> (Back to Sleep Public Education Campaign)

In 1992, the American Academy of Pediatrics (AAP) released a statement recommending that all healthy infants be placed down for sleep on their backs (Pediatrics, 1992;89:1120-1126). This recommendation was based on numerous reports that babies who sleep prone (face down) have a significantly increased likelihood of dying of sudden infant death syndrome (SIDS). The recommendation was reaffirmed in 1994 (Pediatrics, 1994;93:820). Health care professionals are encouraged to read both publications for a review of the evidence that led to the recommendation.

A national campaign (the “Back to Sleep” campaign) was launched in 1994 to promote supine (lying on back) positioning during sleep. Periodic surveys have confirmed that the prevalence of prone sleeping among infants in the United States has decreased from approximately 75 percent in 1992 to 11 percent in 2002. Between 1992 and 2001, there was a more than 50 percent reduction in SIDS deaths, but a slight increase in prone sleeping since 2002 may be contributing to the lack of further reduction.

Although the recommendation appears simple (most babies should be put to sleep on their backs), a variety of questions have arisen about the practicalities of implementation. The AAP Task Force on Infant Sleep Position and SIDS has considered these questions and prepared the following responses. It should be emphasized, however, that for most of these questions there are not sufficient data to provide definitive answers.

Is the side position as effective as the back?

Recent reports indicate that the risk of SIDS is greater for babies placed on their sides versus those placed truly supine. The reason for this difference is that babies placed on their sides have a higher likelihood of spontaneously turning to prone. The AAP now recommends only supine (back) position for sleep.



Chapter 2 Child Growth and Development

Should healthy babies ever be placed prone?

Since the initiation of the national campaign, some parents have misinterpreted the recommendation to say that babies should never be placed prone. This is incorrect. Developmental experts advise that prone positioning during the awake state is important for shoulder girdle motor development to promote head control. Therefore, parents should be advised that a certain amount of “tummy time” when the baby is awake and observed is good.



Which sleeping position is best for a baby born preterm who is ready for discharge?

There have been studies showing that preterm babies who have active respiratory disease have improved oxygenation if they are prone. However, these babies have not been specifically examined as a group once they are recovered from respiratory problems and are ready for hospital discharge. There is no reason to believe that they should be treated any differently than a baby who was born at term.

At what age can you stop using the back position for sleep?

We are unsure of the level of risk associated with prone positioning at specific ages during the first year of life, although there are some data that suggest that the greatest decrease in SIDS incidence in those countries that have changed to mostly non-prone sleeping has been seen in the younger infants (2 to 6 months).

Therefore, the first 6 months, when babies are forming sleeping habits, are probably the most important time to focus on. Nevertheless, until more data suggest otherwise, it seems reasonable to continue to place babies down for sleep supine throughout infancy.

Do I need to keep checking on my baby after laying him or her down for sleep in a non-prone position?

We recommend that parents do not keep checking on their baby after he or she is laid down to sleep. Although the infant's risk of SIDS could be increased slightly if he or she spontaneously assumes the prone position, the risk is not sufficient to outweigh the great disruption to the parents, and possibly to the infant, by frequent checking. Also, studies have shown that it is unusual for a baby who is placed in a supine position to roll into a prone position during early infancy.

Will babies aspirate on their backs?

While this has been a significant concern to health professionals and parents, there is no evidence that healthy babies are more likely to experience serious or fatal aspiration episodes when they are supine. In fact, in the majority of the very small number of reported cases of death due to aspiration, the infant's position at death, when known, was prone.

In addition, indirect reassurance of the safety of the supine position for infants comes from the knowledge that this position has been standard in China, India and other Asian countries for many years. Finally, in countries such as England, Australia and New Zealand, where there has been a major change in infant sleeping position from predominantly prone to predominantly supine or side sleeping, there is no evidence of any increased number of serious or fatal episodes of aspiration of gastric contents.

Will supine sleeping cause flat heads?

There is some suggestion that the incidence of babies developing a flat spot on their occiputs (back part of head or skull) may have increased since the incidence of prone sleeping has decreased. This is almost always a benign condition that will disappear within several months after the baby has begun to sit up.

Flat spots can be avoided by altering the supine head position. Techniques for accomplishing this include turning the head to one side for a week or so and then changing to the other, reversing the head-to-toe axis in the crib and changing the orientation of the baby to outside activity (e.g., the door of the room). "Positional plagiocephaly" seldom, if ever, requires surgery and is quite distinguishable from craniosynostosis.

The risk of positional plagiocephaly can be reduced through a few simple measures:

- Provide an infant with plenty of supervised play time on his or her tummy. This helps build and strengthen neck, shoulder and arm muscles.
- Change the direction that the baby is lying in the crib on a regular basis to ensure he or she is not always resting on the same part of the head. For example, have the baby's feet point toward one end of the crib for a few days, and then change the position so his or her feet point toward the other end of the crib.
- Avoid too much time in car seats, carriers and bouncers while the baby is awake.
- Frequently get "cuddle time" during the day by holding the baby upright over one shoulder.
- When holding, feeding or carrying an infant, make sure that there is no undue pressure placed on the flat side of the head. Change infant's head position from side to side during feeding time.



Chapter 2 Child Growth and Development

- Change the location of the baby's crib in the room so that he or she has to look in different directions to see the door or the window

Should products be used to keep babies on their backs or sides during sleep?

Although various devices have been marketed to maintain babies in a non-prone position during sleep, the Task Force does not recommend their use. None of the studies that showed a reduction in risk when the prevalence of prone sleeping was reduced used devices. No studies examining the relative safety of the devices have been published.

Should soft surfaces be avoided?

Several studies indicate that soft sleeping surfaces increase the risk of SIDS in infants who sleep prone. How soft a surface must be to pose a threat is unknown.

Until more information becomes available, a standard firm infant mattress with no more than a thin covering, such as a sheet or rubberized pad, between the infant and mattress is advised. The U.S. Consumer Product Safety Commission has also warned against placing any soft, plush or bulky items, such as pillows, rolls of bedding or cushions, in the baby's immediate sleeping environment. These items can potentially come into close contact with the infant's face, impeding ventilation or entrapping the infant's head and causing suffocation.





ARKANSAS HEALTHY CHILDREN HANDBOOK

6TH EDITION • 2012

Chapter 3 Social-Emotional Development

Chapter Content

Teach Social-Emotional Skills

Use Strategies to Prevent Tantrums

Recognize the Difference Between a Tantrum and a Meltdown

Teach Children to Follow Rules

Teach Children Problem-solving Steps

Teach Children How to Make Friends

Teaching Strategies for Making Friends and Playing Together

Ten (10) Ways to Support Children's Social-Emotional Skill Building



**ARKANSAS DEPARTMENT OF
HUMAN SERVICES**



Division of Child Care and Early Childhood Education

Chapter 3 **Social-Emotional Development**

Social-Emotional Development is the foundation for behavior, academics and mental health. Children who learn healthy social-emotional skills in preschool will do better in kindergarten. In elementary school they will do better academically and have more friends.

Early problem behaviors such as aggression, anxiety, noncompliance, lack of friends and tantrums indicate a lack of social-emotional skills. Children who do not learn social-emotional skills in preschool are more likely to have bigger problems later such as school failure, delinquency or substance abuse.

The preschool period is a critical time for children to learn to control their thoughts, feelings, attention, impulses and behavior: that is, to learn social-emotional skills. Humans are not born with these skills. Humans are born with the capacity to learn. Teachers and caregivers must teach social-emotional skills just as they teach washing hands or learning colors and shapes.

A child's ability to successfully develop social-emotional skills is highly dependent on warm, nurturing, responsive caregivers. Providers can share information on the importance of social-emotional skills with parents, teach specific skills to children and patiently support children while they learn these skills through daily practice.

Emotional development is the process of learning to recognize and express one's own emotions, regulate or manage emotions and understand the emotions of others.

Social development is the process of developing skills to form positive relationships with adults and peers, play with others and handle challenging situations.

Emotional literacy is the ability to recognize, label and understand feelings. This is one of the most important skills children learn in early childhood.



TEACH SOCIAL-EMOTIONAL SKILLS – STRATEGIES

Teach Feeling Words: Teach children to name their own feelings and the feelings of others. This helps them control emotions, get along with others and solve problems. Teach feeling words during routine activities and during play. Accept children's feelings. Do not minimize their feelings. Teach children to use words to express feelings to others instead of hurtful actions. Read books that talk about feelings.

Chapter 3 **Social-Emotional Development**

Teach a Calm-Down Routine: Just telling a child to “calm down” is not enough. Teach calm-down steps such as taking deep breaths, counting to five, and acknowledging each other’s feelings. It is natural for a young child to scream or act aggressively when they feel strong emotions. They need calm, patient adults to teach and allow them to practice how to calm down.

Teach Children to Ask a Grown-up for Help: Children do better in school when they know to ask a teacher for help. Children who have never learned to trust adults and ask for help when needed are more likely to have problems later. Teach that asking for help is a good thing. When children consistently ask a grown-up for help and then receive patient help from an adult, they gain a sense of control in their life. That’s part of learning self-control.

Teach Children to Make Good Choices: Children who have some control in their life have less need for tantrums. Help children learn to make good choices by giving just the choices that are okay. Such as: a choice between two things (red or blue smock, or an apple cut up or whole). Follow through to make sure a child acts on his or her choice. Praise for making a good choice.

USE STRATEGIES TO PREVENT TANTRUMS

- Give the child a heads up before transitions. (“In 5 minutes it will be time to stop playing.”)
- Notice when a child is becoming frustrated. Help the child identify the feeling and the problem.
- Ignore a tantrum if child is not hurting self or breaking anything. Adult anger, threats and punishment can make tantrums worse.
- If you can’t ignore the tantrum, take child to a quiet place and hold in a loving way.
- Once the child is calm talk about the problem and help find a solution.
- Do not reward a tantrum. Giving a screaming child candy after you’ve said “no” will make it more likely another tantrum will occur.
- Praise a child for calming down. Be a calm example.



RECOGNIZE THE DIFFERENCE BETWEEN A TANTRUM AND A MELTDOWN

Tantrums occur when children resist adult authority and attempt to exert their independence. A meltdown occurs when the child is unable to cope with his/her environment (e.g., overstimulated, hungry, tired, or stressed). For a tantrum, reengage and reassure the child after he or she is calm. For a meltdown, provide comfort. For both, be a calm example.

Teach Children to Follow Rules: Rules (limits) help a child learn what is acceptable and what is not. Practice following rules is practice learning self-control. Help children learn to follow rules:

- Teach and consistently enforce developmentally appropriate rules.
- Let children know the consequences for not following the rules. (Throw the block and you cannot play with it again until tomorrow.)
- Follow through with the consequence calmly and firmly.
- Praise children for following the rules.
- Calmly remind of a forgotten rule to give the child a chance to do it right.

TEACH CHILDREN PROBLEM-SOLVING STEPS

Problem solving is a difficult but important skill. All children have disagreements with peers. Those who are helped through problem-solving steps do better in school, now and later. Those who are simply put in time-out do not learn a better way. It will take much practice. With patient, consistent help, young children can learn to problem solve. When a disagreement arises, calmly walk the children through the steps.

- Get on the children's level and say, "This looks like a problem. What happened?"
- Allow each child to tell what happened. Prompt the child to say how it made him or her feel. Ensure the children they will both get to tell what happened. Don't choose sides.
- Do not judge. Calmly repeat back what was said after each child talks. Show with your words and facial expression that you take their problem seriously. ("That does sound like a problem.")
- Next, prompt the children to come up with solutions – brainstorm. ("What can we do next time instead?")
- Again, do not judge their ideas. Talk them through the solutions and help them pick one solution to try. Restate the solution they will try.
- Stay near and observe. Ask if the solution is working. Praise both children if it works. If it doesn't work, start again from the beginning. Talk them through another solution.



TEACH CHILDREN HOW TO MAKE FRIENDS

Most children need adult guidance to learn how to make friends. Be near when children are playing. Show and tell children how to use words and actions to practice the skills listed below:

- Ask a friend to play
- Make up games
- Cooperate
- Ask a favor
- Use humor
- Solve problems
- Listen to others' play ideas
- Give ideas for play
- Share
- Play games with rules
- Offer to help
- Apologize
- Comfort others
- Give or receive compliment

Some children may be pushy and aggressive, and some may be the opposite, withdrawn. Either way it interferes with their ability to play with others. Teachers can coach the child by giving him or her the words to say and by helping the child practice words and actions that make friends and keep the play going.

TEACHING STRATEGIES FOR MAKING FRIENDS AND PLAYING TOGETHER

Initiate Play:

- Help a child find a play partner. Coach the child on the words to use to start play. Give the child the words needed to greet or ask to play. Examples: "There's Melissa in the sandbox. Go over and say, 'I'd like to play too.'" "There's Pence and Ellie by the fence. Go over and say, 'Hi, can I play too?'"
- Monitor and support the child while he practices this skill until he gains confidence.

Make Friends and Keep the Play Going:

- Teach the child "*Let's*" statements. Example: "Let's play house."
- Help child with role selections. Examples: "You be the mother," or "Let's take the babies to the doctor."

Sharing:

- While engaged with a group of children playing, model sharing and asking others to share. Examples: "May I have a red block? Thank you for sharing." "Yes, I would like to share my crayons with you."
- After the children have seen and heard you sharing and asking for something, coach those who need extra help. Remind them of the words to use.

TEN WAYS TO SUPPORT CHILDREN'S SOCIAL-EMOTIONAL SKILL BUILDING IN THE PRESCHOOL CLASSROOM:

- 1) **Help** a child to persist with a difficult task such as a new puzzle. Use a gentle guiding hand, point and give clues. Make sure the puzzle is not too hard.
- 2) **Help** a child wait for a turn. Offer an alternative activity. Teach the child to ask the peer, "Can I have it next?" Praise the child for patience.
- 3) **Help** a child stay quiet during rest time. Let the child pick the nap music. Praise the child for caring about others and being quiet so they can sleep; give the child a positive consequence for being quiet (such as, "choose an activity after nap").
- 4) **Help** a child use his words, not his hands, on the playground. Actively supervise while on the playground. This allows you to intervene early and guide children to use words to express their emotions. Stay near and join in children's play, following their lead.
- 5) **Help** a child play cooperatively in a center. Start the child out with open-ended questions such as "Who are you going to play with? What are you going to play?" Verbally acknowledge or talk about what the child is playing/doing. Use a buddy system.
- 6) **Help** a child take turns. Use puppets to demonstrate turn taking. Read a story about turn taking. Remind children that everyone will get a turn. Remind of rules.
- 7) **Help** children problem solve during pretend play. Prompt children to identify and try different roles. If children have different play schemes in mind, help them problem solve on how to put their various ideas together.
- 8) **Help** a child who always wants to direct the play. Teach him or her to ask other children what they want to be, and let them help make the play rules and sequences. Help the children pick one idea to do and try another idea next.
- 9) **Help** a passive child voice his or her wishes. Give him or her words to say. Help him or her initiate play and make friends. Stay near and be supportive as needed.
- 10) **Help** children with disagreements. Help children think aloud about the play scenario or game. Allow each to describe their needs and feelings regarding the play. Problem solve on how they could keep the play/game going. Model friendly words and tone of voice. Point out when a child uses friendly words and tone.

Initially you will need to stay near and help children practice the words and actions needed for social-emotional skill building. Eventually children will be able to perform these skills on their own.

Adapted from Social-Emotional Learning Preschool Teacher Training by Patti Bokony and from the Social-Emotional Health topic of TIPS for Great Kids!





ARKANSAS HEALTHY CHILDREN HANDBOOK

6TH EDITION • 2012

Chapter 4 Children's Health Histories, Physical Exams and Immunizations

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**ARKANSAS DEPARTMENT OF
HUMAN SERVICES**



Division of Child Care and Early Childhood Education

Chapter 4 **Children's Health Histories, Physical Exams and Immunizations**

IMMUNIZATION RECORDS AND HEALTH RECORDS AND HISTORY

As a licensed/registered child care facility, it is recommended that you:

- Keep health records of all children that include:
 - » Copy of Immunization Record or a form to record immunizations.

EXAMPLE

DTP – 10/20/98

HbCV (HIB) – 10/20/98

HepB – 10/20/98

- » Special health problems (allergies, medications).
- » Medical information, which includes past illnesses, infections and trauma.
- Check immunization records to make sure children are up to date. You may consider using the Immunization Network for Children (Arkansas State Immunization Registry) to help you access a child's immunization records at https://www.inc.arkansasir.com/inc-prd/security_ui.showLogin.
- Require proof of age-appropriate immunizations upon the child's first day of attendance at child care. Also, immunization charts for health care professionals and easy-to-read versions can be found at the following website: <http://www.cdc.gov/vaccines/recs/acip>
- Contact the Arkansas Department of Health if a parent/guardian has a religious objection to immunizations. The Arkansas Department of Health CD/Immunization Team must grant this exemption. Call 1-501-661-2169 for information.
- Call your local health department if you would like help setting up your records.
- Obtain health history when each child is accepted for care. The health history should include date of last physical exam, allergies, any special health problems and immunization history.



IMMUNIZATIONS FOR STAFF

Safe vaccines are available to protect against many diseases. It is recommended that all child care staff have immunity to the following diseases: Diphtheria, tetanus, measles, mumps, rubella and polio.

Immunity may come in the form of the person being exposed to the illness (natural immunity) or in the form of an immunization (passive immunity). Adults need boosters of tetanus, diphtheria and pertussis vaccine every 10 years. Influenza (flu) vaccine given yearly is also recommended.

GUIDE FOR MEASLES IMMUNIZATION

Adults born before 1957 are generally considered naturally immune to measles and usually do not need to be vaccinated.

Adults born in 1957, or after, should check their health records to see if they were **both**:

- 1) Immunized in 1968 or later, **and**
- 2) Immunized after their first birthday, with live measles vaccine.

IF NOT BOTH OF THE ABOVE, THEY NEED TO BE IMMUNIZED.

Adults born before 1957 are generally considered naturally immune to rubella (German measles) and usually do not need to be vaccinated.

Adults born **in 1957, or after**, should check their health records to see if they were immunized **after** 06-01-69 and **after** their first birthday with live rubella vaccine.

Vaccination would not be necessary for those who have had measles. If you are not sure if you've had measles or were vaccinated, there is no harm in receiving a repeat vaccination. (Employees with a positive rubella titer need not be immunized.)

REGULATIONS FOR REPORTING COMMUNICABLE DISEASE BY CHILD CARE CENTERS

Child care centers are required to report certain communicable diseases because these diseases are of special importance in child care settings, and control measures are often carried out in the center.

Medical personnel are already required to report these conditions. However, it is well documented that reports from these sources are not complete. The purpose of requiring reporting from child care centers is to improve reporting and help ensure that proper control measures are carried out in a timely manner. Reports are encouraged.

WHEN IN DOUBT, REPORT.

In addition to helping to protect the health of staff, attendees and their families, these reporting regulations give legal protection to child care centers that do report.

The following are communicable disease conditions that affect child care centers and must be reported to the Arkansas Department of Health by calling **1-800-482-8888**. (A report to your local health department would also be appreciated.)

HEPATITIS

BACKGROUND: Hepatitis A frequently causes outbreaks in child care centers. However, the main evidence of such outbreaks is the occurrence of disease in staff, older children in the center or older household members of attendees (especially attendees who still wear diapers). If the health department determines that an outbreak may be occurring, immune globulin is generally given to all attendees and staff.

REQUIREMENT: Report all cases of hepatitis (regardless of type, if known) that occur in staff, attendees or members of the household of attendees.

NOTE: *Because the diagnosis of the type of hepatitis may be inaccurate or determination of the type can be delayed, all cases of hepatitis must be reported.*

MENINGITIS

BACKGROUND: A single case of meningococcal meningitis or one or two cases of H. influenzae meningitis occurring in an attendee or staff member frequently results in prophylactic antibiotics being recommended for part or all of the attendees and staff.

REQUIREMENT: Report all cases of meningitis (regardless of type, if known) that occur in attendees or staff. In addition, report all severe infections caused by Haemophilus influenzae type b or meningococcus.

NOTE: *Because the diagnosis of the type of meningitis may be inaccurate or determination of the type can be delayed, all cases of meningitis must be reported.*

PERTUSSIS (WHOOPIING COUGH)

BACKGROUND: Pertussis still occurs, generally caught from older siblings and adults who have mild disease. The pertussis organism is very infectious. The DTaP vaccine is partially protective but only after three doses.

Thus, children less than 7 months old are at high risk of contracting pertussis. If they do, they run a high risk of severe complications and even death.

REQUIREMENT: Report all cases of pertussis (whooping cough).



FEBRILE RASHES

BACKGROUND: Measles can be a severe illness causing hospitalization and even death in children, especially children less than 1 year of age. The measles virus is very infectious.

MMR vaccine is not routinely given until age 12 months. A high percentage of children between 6 and 12 months of age are susceptible. If the health department determines that an attendee may have measles, vaccine or immune globulin is generally given to all unimmunized attendees and staff.

REQUIREMENT: Report all cases with a generalized rash and fever, or measles or rubella in staff, attendees or household members of attendees.

NOTE: *The cause of a febrile rash is often difficult to determine, and confirmation is delayed beyond the time when public health action should be taken.*

Therefore, all febrile rashes should be reported so that the health department can determine what action to take.

DIARRHEA

BACKGROUND: Shigella spreads easily in child care centers from one person to another. It can cause severe illness with seizures or hospitalization for dehydration. Health department personnel can coordinate control through recommendations and culturing of attendees and staff.

Giardia can cause chronic diarrhea and spreads person to person. Salmonella and campylobacter can cause severe diarrhea. This bacteria is generally spread through food.

REQUIREMENT: Report all cases of bloody diarrhea, hospitalization for diarrhea, diarrhea accompanied by fever, shigella, salmonella, campylobacter, giardia, and amebiasis and all suspected outbreaks of diarrhea.

TUBERCULOSIS, DIPHTHERIA, MUMPS

BACKGROUND: Tuberculosis and diphtheria rarely occur in child care centers. However, they are contagious, and thus, control measures need to be implemented. Mumps can also spread in child care centers. Reporting mumps cases would help determine the adequacy of mumps control.

REQUIREMENT: Report all cases of tuberculosis, diphtheria and mumps in staff, attendees or household members of attendees.

UNUSUAL OUTBREAKS OF DISEASE

REQUIREMENT: Report any unusual outbreak of disease.

EXAMPLE

Six children sent home from child care with rash.

OR

Parent called to report that his child has meningitis and will not be in child care for a while.

DISEASES THAT CAN BE PREVENTED BY VACCINATION

Before vaccines were available, measles, mumps, rubella, diphtheria, pertussis, tetanus, polio and Haemophilus influenza type b were common. Every year thousands of children suffered permanent disabilities or died as a result of these diseases. Now, however, the diseases can be prevented. It is extremely important that all children and child care staff be immunized against them.

Some simple rules to prevent the spread of all vaccine-preventable diseases

- Keep immunization records of all children attending the child care up to date.
- All children and staff members attending the child care facility should be up to date with their immunizations.
- Immediately refer any possible case of vaccine-preventable disease to a physician.
- **It is very important that you notify the health department if a case of measles, mumps, rubella, diphtheria, tetanus, pertussis or polio occurs in your center. They will provide directions and assistance regarding the disease. Call toll-free 1-800-482-8888.**
- Always follow the recommendations of the health department and the children's physicians regarding exclusion and treatment of children.



DIPHTHERIA

What is it?

Diphtheria is a severe bacterial infection of the nose and throat. Immunization has virtually eliminated the disease. **If diphtheria is suspected, *immediately* contact the health department for assistance and guidance.**

How does it spread?

Diphtheria spreads through droplets from infected individuals. Diphtheria occurs primarily among non-immunized or inadequately immunized people. Diphtheria can also be spread by people who have the bacteria but do not have the symptoms.

What are the symptoms?

Diphtheria causes a sore throat, slight fever, swollen tonsils with grayish patches and swollen neck glands. Sometimes the infection leads to severe throat swelling that can block breathing. If diphtheria is not treated, it can lead to complications such as paralysis, heart failure or pneumonia.

What is the incubation period?

Two to six days.

What is the period of communicability?

From several days to several weeks. If not treated, it can be spread for as long as two to seven weeks.

How can I prevent or control the spread of the infection?

- Keep immunization records of every child attending the child care center up to date.
- Every child and staff member at the child care center should be required to be up to date with immunization against diphtheria.
- Immediately refer any possible case of diphtheria in your facility to a physician.
- Notify the health department if there is a suspected case of diphtheria.
- All children and staff should be observed for sore throats for seven days following diagnosis of a diphtheria case.
- Incompletely immunized children should see a physician and be temporarily excluded from the child care facility until the situation can be discussed with the health department.
- Children with severe immune deficiencies should be excluded from the child care center until health officials or a physician have determined that the infection poses no risk to the immune-compromised child.

PERTUSSIS

What is it?

Pertussis (whooping cough) is a very contagious, potentially life-threatening respiratory disease. It causes the airways to become blocked with mucus. In the United States, more than 75 percent of reported pertussis cases occur in children younger than 5 years.

How does it spread?

By respiratory droplets that are expelled into the air (coughing, sneezing, etc.)

What are the symptoms?

Pertussis begins with cold symptoms that usually last one to two weeks and then develops into repeated attacks of coughing that can interfere with eating, drinking and breathing. These coughing spells end in a high-pitched “whoop” as air is taken in. This stage of coughing usually lasts one to four weeks. During the severe coughing stage, seizures or even death can occur due to the lack of oxygen supply. Duration of the illness is about six to ten weeks.

What is the incubation period?

One to two weeks.

What is the period of communicability?

Pertussis is most contagious during the stage before the severe coughing and remains contagious until three weeks after the coughing begins. Those treated with antibiotics are contagious for only five to seven days after treatment begins. Pertussis is very contagious, and the attack rate has approached 100 percent in susceptible household contacts. Pertussis occurs year-round, with attacks peaking in late summer and early fall.

How can I prevent or control the spread of the infection?

- Keep immunization records of every child attending the child care center up to date.
- Every child attending child care should be required to be up to date with immunizations against pertussis.
- Refer any possible case of pertussis to a physician.
- Notify the health department if there is a suspected case of pertussis.
- Notify parents of children attending child care if a child is diagnosed with pertussis.
- Children with pertussis, if their medical condition allows, may return to or enter a child care facility five days after initiation of appropriate antibiotic therapy.
- Inadequately immunized children should be excluded from child care.



Chapter 4 **Children's Health Histories, Physical Exams and Immunizations**

- For two weeks, be especially alert for coughs in other children. Children who develop a cough should be sent home until diagnosed by a physician.
- Ensure that all staff are up to date on receiving Tdap (tetanus-diphtheria-pertussis) booster shots, recommended once every 10 years.

TETANUS

What is it?

Tetanus (also called “lockjaw”) is a rare, serious bacterial infection. The bacteria live in soil, dust, animal feces and rusty metal. They enter the body through cuts or wounds and produce a poisonous substance that affects the nervous system. This causes the muscles of the body to go into spasms. Tetanus is preventable if the person has the recommended immunizations and gets a booster every 10 years. (A person should receive a booster within five years of an injury.)

How does it spread?

Tetanus occurs almost exclusively in non-immunized or inadequately immunized persons. Tetanus spreads when a person comes into contact with contaminated soil, dust, animal feces or rusty metal.

What are the symptoms?

The first symptoms are usually headache, irritability and muscular stiffness in the jaw and neck. Tetanus can cause painful muscle spasms, paralysis or even death. Muscle spasms, which affect the entire body, including the jaw muscles, make swallowing and breathing difficult.

What is the incubation period?

Approximately three days to three weeks; average of eight days.

What is the period of communicability?

Tetanus cannot be spread from person to person.

How can I prevent or control the spread of the infection?

- Keep immunization records on every child attending the child care up to date to assess.
- Every child attending child care should be required to be up to date with immunizations against tetanus.
- Refer any possible case of tetanus to a physician.
- Report any case of tetanus to the health department.
- Exclude children with tetanus until they have recovered.
- Be sure all cuts, scrapes and puncture wounds are cleaned well with soap and water.

MEASLES

NOTE: *All children should receive MMR immunization at 12-15 months of age. This protects them from measles (“hard,” “red,” “10-day measles,” “rubeola”), mumps and rubella (“German or three-day measles”).*

What is it?

Measles (“rubeola,” “hard,” “red” or “seven-day” measles) is one of the most serious viral infections of childhood. Among people who are not immunized, measles is one of the most easily spread childhood diseases. Before measles vaccine was available, there were hundreds of thousands of cases and hundreds of deaths each year. However, if children are not vaccinated, they have a high risk of getting measles, either in childhood or later in life.

How does it spread?

Direct contact with infectious droplets or, less commonly, by airborne spread.

What are the symptoms?

Measles begins with symptoms similar to those of a common cold: runny nose, watery eyes and a high fever. A brownish-red rash usually begins three to four days later on the face and spreads down the body. The rash usually lasts four to seven days.

The child is usually ill one to two weeks. Sometimes measles can cause ear infections, pneumonia or encephalitis (inflammation of the brain). This can lead to convulsions, deafness or mental retardation. Measles can also cause miscarriages or premature delivery in pregnant women.

What is the incubation period?

Ten to fourteen days.

What is the period of communicability?

Measles is contagious from three to four days before the onset of cold-like symptoms until four days after appearance of the rash.

How can I prevent or control the spread of the infection?

- Keep immunization records of every child attending the child care up to date.
- Every child attending child care should be required to be up to date with immunizations against measles.
- Refer any possible case of measles to a physician.
- Notify the health department – **IMMEDIATELY** – if there is a suspected case of measles.
- **Always** follow the recommendations of the health department and the children's physicians regarding exclusion and treatment of children.



MUMPS

What is it?

Mumps is an infectious childhood disease, mostly affecting children over 2 years old. It is a very contagious viral illness that can be prevented through proper immunization.

How does it spread?

Respiratory droplets spread by sneezing, coughing or any activity that causes droplets to spread in the air.

What are the symptoms?

Common symptoms are fever, headache, swelling and tenderness in the salivary glands (which causes both sides of the face below the ears and beneath the chin to swell). The swelling can cause pain when swallowing and dry mouth. Possible complications include inflammation of the brain (meningitis), deafness and miscarriage if infection occurs during the first trimester of pregnancy.

What is the incubation period?

Fourteen to twenty-one days.

What is the period of communicability?

Mumps is contagious about seven days before swelling begins until swelling subsides. The disease is most infectious 48 hours before onset of symptoms but can be spread a week or more before and after symptoms begin

How can I prevent or control the spread of the infection?

- Keep immunization records of every child attending the child care up to date.
- Every child attending child care should be required to be up to date with immunizations against mumps.
- Refer any possible case of mumps to a physician.
- Notify the health department if there is a suspected case of mumps. Follow health department recommendations.
- Children with mumps should be excluded from child care until nine days after the onset of swelling or until swelling has subsided.
- If any child is not protected against mumps, contact his or her physician as soon as possible to have the child immunized.

- If additional children develop fever or swollen glands, advise parents to keep them home and consult a physician for a diagnosis.
- The mumps vaccine is very effective and produces long-lasting protection (probably lifelong).

RUBELLA

What is it?

Rubella ("German" or "three-day" measles) is a mild viral illness that can be prevented by immunization.

How does it spread?

Through respiratory secretions spread by sneezing or coughing, and by direct contact with infected nasal or oral secretions.

What are the symptoms?

In children, rubella may cause a rash, low fever and swollen glands at the back of the neck. The sickness usually lasts about three days. The rash is usually flat and red. It begins behind the ears and spreads to the rest of the body over the next 24 hours.

Adults usually have a more serious illness than children. If a pregnant woman becomes infected, her developing fetus can also become infected, resulting in stillbirth, miscarriage or serious birth defects.

What is the incubation period?

Two to three weeks.

What is the period of communicability?

From one week before the appearance of the rash until disappearance of the rash.

How can I prevent or control the spread of the infection?

- Keep accurate immunization records of all children who attend the child care.
- Every child attending child care should be required to be up to date with immunizations against rubella.
- Notify the health department if there is a suspected case of rubella. Follow health department recommendations.
- Exclude the infected children for seven days after the rash appears.
- Inadequately immunized children should be excluded from the child care.



Chapter 4 **Children's Health Histories, Physical Exams and Immunizations**

- If additional children develop rash, fever and swollen glands, tell the parents to keep them home and notify their physicians.
- Any pregnant staff members should see their physicians if a rubella case is suspected.
- Be careful about good hygiene.
- The rubella vaccine is highly effective and produces long-lasting protection (usually lifelong).
- All staff members should be immunized against rubella before starting to work. (Women should not receive the vaccine if they are pregnant or might become pregnant within three months.)

POLIO

What is it?

Poliomyelitis (Polio) is a contagious viral infection of the spinal cord and nerves that can cause permanent paralysis and occasionally death in non-immunized adults and children.

How does it spread?

Direct contact with respiratory droplets and stool from the infected person. Many people who are infected by the polio virus have no symptoms but may still spread the infection to others.

What are the symptoms?

Mild forms of polio cause high fever, sore throat, nausea, headache, stomachache and pain and stiffness in the neck, back and legs. Paralytic polio begins with the same symptoms, but severe muscle pain is usually present and paralysis occurs within the first week. Paralysis usually occurs in the lower limbs or in the chest, causing loss of breath and eventually death.

What is the incubation period?

Mild: three to six days. Paralytic polio: seven to twenty-one days.

What is the period of communicability?

Polio is most infectious shortly before and after the onset of symptoms.

How can I prevent or control the spread of the infection?

- Keep immunization records of every child attending the child care up to date.
- Every child attending child care should be required to be up to date with immunizations against polio.
- Refer any possible case of polio to a physician.

- Notify the health department if there is a suspected case of polio. Follow health department recommendations.
- Exclude children and staff who have polio for one week from onset of the disease or until the fever is gone.
- There is no specific treatment for polio, thus the need for the immunization.
- Notify all parents and staff if a case of polio occurs.

HAEMOPHILUS INFLUENZA TYPE B

What is it?

Haemophilus influenza type B (HIB) is a bacterium that causes meningitis. It is most common in children 3 months to 3 years old. More than half of HIB cases occur in infants 6-12 months old. Thus, preschool children are at the highest risk for the disease. Numerous clusters of cases of HIB have been reported in child care facilities. In addition, HIB is responsible for cases of septicemia (a bloodstream infection), epiglottitis (infection of the upper throat), pneumonia (infection of the lung), arthritis (infection of the joints) and cellulitis (infection of the deep skin tissues).

How does it spread?

By respiratory droplets from infected individuals. Some healthy people carry the bacteria in their nose or throat without becoming ill. Both sick people and carriers may spread the bacteria to other persons who may then become ill.

What are the symptoms?

The symptoms of HIB are related to the specific disease that HIB causes. The following are some of the symptoms to look for when an HIB infection has possibly occurred:

- **Meningitis** – sleepiness, fever, stiff neck, vomiting, headache and irritability
- **Cellulitis** – tender and rapid swelling of the skin
- **Epiglottitis** – fever, trouble swallowing, tiredness, and difficult and rapid breathing
- **Pneumonia** – fever and cough
- **Arthritis** – swelling, redness and aching of the joints
- **Septicemia** – fever, chills and irritability

What is the incubation period?

Probably less than 10 days.



Chapter 4 **Children's Health Histories, Physical Exams and Immunizations**

What is the period of communicability?

Unknown. May be as long as the infectious organism is present.

How can I prevent or control the spread of the infection?

- Keep accurate immunization records of all children who attend the child care up to date.
- It is highly recommended that all children 2 months old start the Hib vaccine series.
- Notify the health department if Hib illness develops. Follow health department recommendations and the children's physicians regarding exclusion and treatment of children.

REYE'S SYNDROME

What is it?

Reye's Syndrome is a disorder characterized by vomiting, disorientation and progressive loss of consciousness. It may occur shortly after a viral illness (such as influenza or chicken pox if a child is given aspirin).

How does it spread?

The exact process is unknown but Reye's Syndrome does not seem to spread from person to person.

What are the symptoms?

Vomiting, sleepiness, disorientation, agitation, and potentially coma and death are some symptoms of Reye's Syndrome.

How can I prevent or control the spread of the infection?

- Do not give any child aspirin until you have discussed it with the physician.
- Call the child's physician or emergency room immediately if symptoms of vomiting and altered consciousness occur. Fast action is required to prevent any complications.

2012 Recommended Immunizations for Children from Birth Through 6 Years Old

	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19-23 months	2-3 years	4-6 years
HepB		HepB						HepB			
RV		RV	RV	RV	RV						
DTaP		DTaP	DTaP	DTaP	DTaP			DTaP			DTaP
Hib		Hib	Hib	Hib	Hib			Hib			
PCV		PCV	PCV	PCV	PCV			PCV [†]			
IPV		IPV	IPV	IPV				IPV			IPV
Influenza (Yearly)*											
MMR								MMR			MMR
Varicella								Varicella			Varicella
HepA ^{\$}											

* Shaded boxes indicate the vaccine can be given during shown age range.

Shaded boxes indicate the vaccine can be given during shown age range.

NOTE: If your child misses a shot, you don't need to start over, just go back to your child's doctor for the next shot. The doctor will keep your child up-to-date on vaccinations. Talk with your doctor if you have questions.

For more information, call toll free
1-800-CDC-INFO (1-800-232-4636)
or visit
<http://www.cdc.gov/vaccines>

FOOTNOTES

† Children 2 years old and older with certain medical conditions may need a dose of pneumococcal vaccine (PPSV) and meningococcal vaccine (MCV4). See vaccine-specific recommendations at <http://www.cdc.gov/vaccines/pubs/ACIP-list.htm>.

* Two doses given at least four weeks apart are recommended for children aged 6 months through 8 years of age who are getting a flu vaccine for the first time.

Two doses of HepA vaccine are needed for lasting protection. The first dose of HepA vaccine should be given between 12 months and 23 months of age. The second dose should be given 6 to 18 months later. HepA vaccination may be given to any child 12 months and older to protect against HepA. Children and adolescents who did not receive the HepA vaccine and are at high-risk, should be vaccinated against HepA.

SEE BACK PAGE
FOR MORE
INFORMATION ON
VACCINE-
PREVENTABLE
DISEASES AND THE
VACCINES THAT
PREVENT THEM



**U.S. Department of
Health and Human Services**
Centers for Disease
Control and Prevention





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DEDICATED TO THE HEALTH OF ALL CHILDREN[®]

2012 Recommended Immunizations for Children from 7 Through 18 Years Old

7-10 YEARS	11-12 YEARS	13-18 YEARS
		
Tdap ¹	Tetanus, Diphtheria, Pertussis (Tdap) Vaccine	Tdap
MCV4	Human Papillomavirus (HPV) Vaccine (3 Doses) ²	HPV
	Meningococcal Conjugate Vaccine (MCV4) Dose 1 ³	MCV4 Dose 1 ³
	Influenza (Yearly) ⁴	Booster at age 16 years
	Pneumococcal Vaccine ⁵	
	Hepatitis A (HepA) Vaccine Series ⁶	
	Hepatitis B (HepB) Vaccine Series	
	Inactivated Polio Vaccine (IPV) Series	
	Measles, Mumps, Rubella (MMR) Vaccine Series	
	Varicella Vaccine Series	

 These shaded boxes indicate when the vaccine is recommended for all children unless your doctor tells you that your child cannot safely receive the vaccine.

 These shaded boxes indicate the vaccine should be given if a child is catching-up on missed vaccines.

 These shaded boxes indicate the vaccine is recommended for children with certain health conditions that put them at high risk for serious diseases. Note that healthy children **can** get the HepA series⁶. See vaccine-specific recommendations at www.cdc.gov/vaccines/pubs/ACIP-list.htm.

FOOTNOTES

¹ Tdap vaccine is combination vaccine that is recommended at age 11 or 12 to protect against tetanus, diphtheria and pertussis. If your child has not received any or all of the DTaP vaccine series, or if you don't know if your child has received these shots, your child needs a single dose of Tdap when they are 7-10 years old. Talk to your child's health care provider to find out if they need additional catch-up vaccines.

² All 11 or 12 year olds – both girls and boys – should receive 3 doses of HPV vaccine to protect against HPV-related disease. Either HPV vaccine (Cervarix[®] or Gardasil[®]) can be given to girls and young women; only one HPV vaccine (Gardasil[®]) can be given to boys and young men.

³ Meningococcal conjugate vaccine (MCV) is recommended at age 11 or 12. A booster shot is recommended at age 16. Teens who received MCV for the first time at age 13 through 15 years will need a one-time booster dose between the ages of 16 and 18 years. If your teenager missed getting the vaccine altogether, ask their health care provider about getting it now, especially if your teenager is about to move into a college dorm or military barracks.

⁴ Everyone 6 months of age and older—including preteens and teens—should get a flu vaccine every year. Children under the age of 9 years may require more than one dose. Talk to your child's health care provider to find out if they need more than one dose.

⁵ A single dose of Pneumococcal Conjugate Vaccine (PCV13) is recommended for children who are 6-18 years old with certain medical conditions that place them at high risk. Talk to your healthcare provider about pneumococcal vaccine and what factors may place your child at high risk for pneumococcal disease.

⁶ Hepatitis A vaccination is recommended for older children with certain medical conditions that place them at high risk. HepA vaccine is licensed, safe, and effective for all children of all ages. Even if your child is not at high risk, you may decide you want your child protected against HepA. Talk to your healthcare provider about HepA vaccine and what factors may place your child at high risk for HepA.

For more information, call toll free 1-800-CDC-INFO (1-800-232-4636) or visit <http://www.cdc.gov/vaccines/teens>



U.S. Department of
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Vaccine-Preventable Diseases and the Vaccines that Prevent Them

Disease	Vaccine	Disease spread by	Disease symptoms	Disease complications
Chickenpox	Varicella vaccine protects against chickenpox.	Air, direct contact	Rash, tiredness, headache, fever	Infected blisters, bleeding disorders, encephalitis (brain swelling), pneumonia (infection in the lungs)
Diphtheria	DTaP* vaccine protects against diphtheria.	Air, direct contact	Sore throat, mild fever, weakness, swollen glands in neck	Swelling of the heart muscle, heart failure, coma, paralysis, death
Hib	Hib vaccine protects against <i>Haemophilus influenzae</i> type b.	Air, direct contact	May be no symptoms unless bacteria enter the blood	Meningitis (infection of the covering around the brain and spinal cord), mental retardation, epiglottitis (life-threatening infection that can block the windpipe and lead to serious breathing problems) and pneumonia (infection in the lungs), death
HepA	HepA vaccine protects against hepatitis A.	Personal contact, contaminated food or water	May be no symptoms, fever, stomach pain, loss of appetite, fatigue, vomiting, jaundice (yellowing of skin and eyes), dark urine	Liver failure
HepB	HepB vaccine protects against hepatitis B.	Contact with blood or body fluids	May be no symptoms, fever, headache, weakness, vomiting, jaundice (yellowing of skin and eyes), joint pain	Chronic liver infection, liver failure, liver cancer
Flu	Flu vaccine protects against influenza.	Air, direct contact	Fever, muscle pain, sore throat, cough, extreme fatigue	Pneumonia (infection in the lungs)
Measles	MMR** vaccine protects against measles.	Air, direct contact	Rash, fever, cough, runny nose, pinkeye	Encephalitis (brain swelling), pneumonia (infection in the lungs), death
Mumps	MMR** vaccine protects against mumps.	Air, direct contact	Swollen salivary glands (under the jaw), fever, headache, tiredness, muscle pain	Meningitis (infection of the covering around the brain and spinal cord), encephalitis (brain swelling), inflammation of testicles or ovaries, deafness
Pertussis	DTaP* vaccine protects against pertussis (whooping cough).	Air, direct contact	Severe cough, runny nose, apnea (a pause in breathing in infants)	Pneumonia (infection in the lungs), death
Polio	IPV vaccine protects against polio.	Through the mouth	May be no symptoms, sore throat, fever, nausea, headache	Paralysis, death
Pneumococcal	PCV vaccine protects against pneumococcus.	Air, direct contact	May be no symptoms, pneumonia (infection in the lungs)	Bacteremia (blood infection), meningitis (infection of the covering around the brain and spinal cord), death
Rotavirus	RV vaccine protects against rotavirus.	Through the mouth	Diarrhea, fever, vomiting	Severe diarrhea, dehydration
Rubella	MMR** vaccine protects against rubella.	Air, direct contact	Children infected with rubella virus sometimes have a rash, fever, and swollen lymph nodes.	Very serious in pregnant women—can lead to miscarriage, stillbirth, premature delivery, and birth defects
Tetanus	DTaP* vaccine protects against tetanus.	Exposure through cuts in skin	Stiffness in neck and abdominal muscles, difficulty swallowing, muscle spasms, fever	Broken bones, breathing difficulty, death

* DTaP is a combination vaccine that protects against diphtheria, tetanus, and pertussis.

** MMR is a combination vaccine that protects against measles, mumps, and rubella.

Last updated on 02/01/2012 - CS229912.8



Recommended Immunization Schedule for Persons Aged 0 Through 6 years – United States, 2012

Vaccine ▼	Age ►	Birth	1 month	2 months	4 months	6 months	9 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years	
Hepatitis B ¹		Hep B	HepB			HepB								Range of recommended ages for all children
Rotavirus ²			RV	RV	RV ²									
Diphtheria, tetanus, pertussis ³			DTaP	DTaP	DTaP		see footnote ³	DTaP					DTaP	
<i>Haemophilus influenzae</i> type b ⁴			Hib	Hib	Hib ⁴			Hib						Range of recommended ages for certain high-risk groups
Pneumococcal ⁵			PCV	PCV	PCV			PCV				PPSV		
Inactivated poliovirus ⁶			IPV	IPV		IPV							IPV	
Influenza ⁷								Influenza (Yearly)						
Measles, mumps, rubella ⁸								MMR		see footnote ⁸			MMR	Range of recommended ages for all children and certain high-risk groups
Varicella ⁹								Varicella		see footnote ⁹			Varicella	
Hepatitis A ¹⁰								Dose 1 ¹⁰				HepA Series		
Meningococcal ¹¹								MCV4 — see footnote ¹¹						

This schedule includes recommendations in effect as of December 23, 2011. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (<http://www.vaers.hhs.gov>) or by telephone (800-822-7967).

- Hepatitis B (HepB) vaccine.** (Minimum age: birth)
 - At birth:**
 - Administer monovalent HepB vaccine to all newborns before hospital discharge.
 - For infants born to hepatitis B surface antigen (HBsAg)-positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) 1 to 2 months after completion of at least 3 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit).
 - If mother's HBsAg status is unknown, within 12 hours of birth administer HepB vaccine for infants weighing ≥2,000 grams, and HepB vaccine plus HBIG for infants weighing <2,000 grams. Determine mother's HBsAg status as soon as possible and, if she is HBsAg-positive, administer HBIG for infants weighing ≥2,000 grams (no later than age 1 week).
 - Doses after the birth dose:**
 - The second dose should be administered at age 1 to 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks.
 - Administration of a total of 4 doses of HepB vaccine is permissible when a combination vaccine containing HepB is administered after the birth dose.
 - Infants who did not receive a birth dose should receive 3 doses of a HepB-containing vaccine starting as soon as feasible (Figure 3).
 - The minimum interval between dose 1 and dose 2 is 4 weeks, and between dose 2 and 3 is 8 weeks. The final (third or fourth) dose in the HepB vaccine series should be administered no earlier than age 24 weeks and at least 16 weeks after the first dose.
- Rotavirus (RV) vaccines.** (Minimum age: 6 weeks for both RV-1 [RotaTrix] and RV-5 [Rota Teq])
 - The maximum age for the first dose in the series is 14 weeks, 6 days; and 8 months, 0 days for the final dose in the series. Vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
 - If RV-1 (RotaTrix) is administered at ages 2 and 4 months, a dose at 6 months is not indicated.
- Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine.** (Minimum age: 6 weeks)
 - The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
- Haemophilus influenzae* type b (Hib) conjugate vaccine.** (Minimum age: 6 weeks)
 - If PRP-OMP (PedvaxHIB or Comvax [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
 - Hiberix should only be used for the booster (final) dose in children aged 12 months through 4 years.
- Pneumococcal vaccines.** (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])
 - Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
 - For children who have received an age-appropriate series of 7-valent PCV (PCV7), a single supplemental dose of 13-valent PCV (PCV13) is recommended for:
 - All children aged 14 through 59 months
 - Children aged 60 through 71 months with underlying medical conditions.
 - Administer PPSV at least 8 weeks after last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. See *MMWR* 2010;59(No. RR-11), available at <http://www.cdc.gov/mmwr/pdf/rr/r5911.pdf>.
- Inactivated poliovirus vaccine (IPV).** (Minimum age: 6 weeks)
 - If 4 or more doses are administered before age 4 years, an additional dose should be administered at age 4 through 6 years.
 - The final dose in the series should be administered on or after the fourth birthday and at least 6 months after the previous dose.
- Influenza vaccines.** (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])
 - For most healthy children aged 2 years and older, either LAIV or TIV may be used. However, LAIV should not be administered to some children, including 1) children with asthma, 2) children 2 through 4 years who had wheezing in the past 12 months, or 3) children who have any other underlying medical conditions that predispose them to influenza complications. For all other contraindications to use of LAIV, see *MMWR* 2010;59(No. RR-8), available at <http://www.cdc.gov/mmwr/pdf/rr/r5908.pdf>.
 - For children aged 6 months through 8 years:
 - For the 2011–12 season, administer 2 doses (separated by at least 4 weeks) to those who did not receive at least 1 dose of the 2010–11 vaccine. Those who received at least 1 dose of the 2010–11 vaccine require 1 dose for the 2011–12 season.
 - For the 2012–13 season, follow dosing guidelines in the 2012 ACIP influenza vaccine recommendations.
- Measles, mumps, and rubella (MMR) vaccine.** (Minimum age: 12 months)
 - The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.
 - Administer MMR vaccine to infants aged 6 through 11 months who are traveling internationally. These children should be revaccinated with 2 doses of MMR vaccine, the first at ages 12 through 15 months and at least 4 weeks after the previous dose, and the second at ages 4 through 6 years.
- Varicella (VAR) vaccine.** (Minimum age: 12 months)
 - The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose.
 - For children aged 12 months through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
- Hepatitis A (HepA) vaccine.** (Minimum age: 12 months)
 - Administer the second (final) dose 6 to 18 months after the first.
 - Unvaccinated children 24 months and older at high risk should be vaccinated. See *MMWR* 2006;55(No. RR-7), available at <http://www.cdc.gov/mmwr/pdf/rr/r5507.pdf>.
 - A 2-dose HepA vaccine series is recommended for anyone aged 24 months and older, previously unvaccinated, for whom immunity against hepatitis A virus infection is desired.
- Meningococcal conjugate vaccines, quadrivalent (MCV4).** (Minimum age: 9 months for Menactra [MCV4-D]; 2 years for Menveo [MCV4-CRM])
 - For children aged 9 through 23 months 1) with persistent complement component deficiency; 2) who are residents of or travelers to countries with hyperendemic or epidemic disease; or 3) who are present during outbreaks caused by a vaccine serogroup, administer 2 primary doses of MCV4-D, ideally at ages 9 months and 12 months or at least 8 weeks apart.
 - For children aged 24 months and older with 1) persistent complement component deficiency who have not been previously vaccinated; or 2) anatomic/functional asplenia, administer 2 primary doses of either MCV4 at least 8 weeks apart.
 - For children with anatomic/functional asplenia, if MCV4-D (Menactra) is used, administer at a minimum age of 2 years and at least 4 weeks after completion of all PCV doses.
 - See *MMWR* 2011;60:72–6, available at <http://www.cdc.gov/mmwr/pdf/wk/mm6003.pdf>, and *Vaccines for Children Program resolution No. 6/11-1*, available at <http://www.cdc.gov/vaccines/programs/vfc/downloads/resolutions/06-11mening-mcv.pdf>, and *MMWR* 2011;60:1391–2, available at <http://www.cdc.gov/mmwr/pdf/wk/mm6040.pdf>, for further guidance, including revaccination guidelines.

This schedule is approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/vaccines/recs/acip>), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).
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Recommended Immunization Schedule for Persons Aged 7 Through 18 years – United States, 2012

Vaccine ▼	Age ►	7–10 years	11–12 years	13–18 years	
Tetanus, diphtheria, pertussis ¹		1 dose (if indicated)	1 dose	1 dose (if indicated)	Range of recommended ages for all children
Human papillomavirus ²		see footnote ³	3 doses	Complete 3-dose series	
Meningococcal ³		See footnote ³	Dose 1	Booster at 16 years old	Range of recommended ages for catch-up immunization
Influenza ⁴		Influenza (yearly)			
Pneumococcal ⁵		See footnote ⁵			
Hepatitis A ⁶		Complete 2-dose series			
Hepatitis B ⁷		Complete 3-dose series			
Inactivated poliovirus ⁸		Complete 3-dose series			Range of recommended ages for certain high-risk groups
Measles, mumps, rubella ⁹		Complete 2-dose series			
Varicella ¹⁰		Complete 2-dose series			

This schedule includes recommendations in effect as of December 23, 2011. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (<http://www.vaers.hhs.gov>) or by telephone (800-822-7967).

- Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine.** (Minimum age: 10 years for Boostrix and 11 years for Adacel)
 - Persons aged 11 through 18 years who have not received Tdap vaccine should receive a dose followed by tetanus and diphtheria toxoids (Td) booster doses every 10 years thereafter.
 - Tdap vaccine should be substituted for a single dose of Td in the catch-up series for children aged 7 through 10 years. Refer to the catch-up schedule if additional doses of tetanus and diphtheria toxoid-containing vaccine are needed.
 - Tdap vaccine can be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.
- Human papillomavirus (HPV) vaccines (HPV4 [Gardasil] and HPV2 [Cervarix]).** (Minimum age: 9 years)
 - Either HPV4 or HPV2 is recommended in a 3-dose series for females aged 11 or 12 years. HPV4 is recommended in a 3-dose series for males aged 11 or 12 years.
 - The vaccine series can be started beginning at age 9 years.
 - Administer the second dose 1 to 2 months after the first dose and the third dose 6 months after the first dose (at least 24 weeks after the first dose).
 - See *MMWR* 2010;59:626–32, available at <http://www.cdc.gov/mmwr/pdf/wk/mm5920.pdf>.
- Meningococcal conjugate vaccines, quadrivalent (MCV4).**
 - Administer MCV4 at age 11 through 12 years with a booster dose at age 16 years.
 - Administer MCV4 at age 13 through 18 years if patient is not previously vaccinated.
 - If the first dose is administered at age 13 through 15 years, a booster dose should be administered at age 16 through 18 years with a minimum interval of at least 8 weeks after the preceding dose.
 - If the first dose is administered at age 16 years or older, a booster dose is not needed.
 - Administer 2 primary doses at least 8 weeks apart to previously unvaccinated persons with persistent complement component deficiency or anatomic/functional asplenia, and 1 dose every 5 years thereafter.
 - Adolescents aged 11 through 18 years with human immunodeficiency virus (HIV) infection should receive a 2-dose primary series of MCV4, at least 8 weeks apart.
 - See *MMWR* 2011;60:72–76, available at <http://www.cdc.gov/mmwr/pdf/wk/mm6003.pdf>, and Vaccines for Children Program resolution No. 6/11-1, available at <http://www.cdc.gov/vaccines/programs/vfc/downloads/resolutions/06-11mening-mcv.pdf>, for further guidelines.
- Influenza vaccines (trivalent inactivated influenza vaccine [TIV] and live, attenuated influenza vaccine [LAIV]).**
 - For most healthy, nonpregnant persons, either LAIV or TIV may be used, except LAIV should not be used for some persons, including those with asthma or any other underlying medical conditions that predispose them to influenza complications. For all other contraindications to use of LAIV, see *MMWR* 2010;59(No. RR-8), available at <http://www.cdc.gov/mmwr/pdf/rr/rr5908.pdf>.
 - Administer 1 dose to persons aged 9 years and older.
- For children aged 6 months through 8 years:
 - For the 2011–12 season, administer 2 doses (separated by at least 4 weeks) to those who did not receive at least 1 dose of the 2010–11 vaccine. Those who received at least 1 dose of the 2010–11 vaccine require 1 dose for the 2011–12 season.
 - For the 2012–13 season, follow dosing guidelines in the 2012 ACIP influenza vaccine recommendations.
- Pneumococcal vaccines (pneumococcal conjugate vaccine [PCV] and pneumococcal polysaccharide vaccine [PPSV]).**
 - A single dose of PCV may be administered to children aged 6 through 18 years who have anatomic/functional asplenia, HIV infection or other immunocompromising condition, cochlear implant, or cerebral spinal fluid leak. See *MMWR* 2010;59(No. RR-11), available at <http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf>.
 - Administer PPSV at least 8 weeks after the last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. A single revaccination should be administered after 5 years to children with anatomic/functional asplenia or an immunocompromising condition.
- Hepatitis A (HepA) vaccine.**
 - HepA vaccine is recommended for children older than 23 months who live in areas where vaccination programs target older children, who are at increased risk for infection, or for whom immunity against hepatitis A virus infection is desired. See *MMWR* 2006;55(No. RR-7), available at <http://www.cdc.gov/mmwr/pdf/rr/rr5507.pdf>.
 - Administer 2 doses at least 6 months apart to unvaccinated persons.
- Hepatitis B (HepB) vaccine.**
 - Administer the 3-dose series to those not previously vaccinated.
 - For those with incomplete vaccination, follow the catch-up recommendations (Figure 3).
 - A 2-dose series (doses separated by at least 4 months) of adult formulation Recombivax HB is licensed for use in children aged 11 through 15 years.
- Inactivated poliovirus vaccine (IPV).**
 - The final dose in the series should be administered at least 6 months after the previous dose.
 - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.
 - IPV is not routinely recommended for U.S. residents aged 18 years or older.
- Measles, mumps, and rubella (MMR) vaccine.**
 - The minimum interval between the 2 doses of MMR vaccine is 4 weeks.
- Varicella (VAR) vaccine.**
 - For persons without evidence of immunity (see *MMWR* 2007;56[No. RR-4], available at <http://www.cdc.gov/mmwr/pdf/rr/rr5604.pdf>), administer 2 doses if not previously vaccinated or the second dose if only 1 dose has been administered.
 - For persons aged 7 through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.
 - For persons aged 13 years and older, the minimum interval between doses is 4 weeks.

This schedule is approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/vaccines/recs/acip>), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).
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ARKANSAS HEALTHY CHILDREN HANDBOOK

6TH EDITION • 2012

Chapter 5 Nutrition and Physical Activity

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**ARKANSAS DEPARTMENT OF
HUMAN SERVICES**



Division of Child Care and Early Childhood Education

Chapter 5 **Nutrition and Physical Activity**

Infants and children, as well as adults, need to eat a balanced diet to grow properly and stay healthy. Positive experiences with physical activity at a young age help lay the basis for being regularly active throughout life. Promoting healthy eating habits and increased physical activity through child care centers helps prevent childhood obesity.

NUTRITION:

A balanced diet includes eating a variety of:

- Fruits and vegetables
- Cereals and grains, including whole grains
- Milk products
- Meat, poultry, fish, beans and eggs

The toddler and preschool years are an important time for children to develop good eating habits that last a lifetime.

FEEDING INFANTS (BIRTH - 1 YEAR)

Infants need breast milk or iron-fortified formula for at least the first year of life. Begin solid foods when the infant is nutritionally and developmentally ready for them. This is between the ages of 4-6 months. It is not recommended to give solids to an infant under 4-6 months because:

- Breast milk (or iron-fortified infant formula) meets all of their nutritional needs.
- Young infants may have trouble digesting solid foods.
- Early introduction to solid foods may contribute to food allergies because of the immature intestinal system.
- Babies under 4-6 months do not have the mouth, tongue or head control needed to swallow foods safely. Infants under 4 months will swallow cereal or any solid food without chewing. They are more likely to choke on solids swallowed this way.
- Solid foods will not help babies sleep through the night. They sleep through the night when their bodies and nervous systems mature and are ready to sleep more hours.



Chapter 5 **Nutrition and Physical Activity**

Many people have different ideas about infant feeding. Child care providers should follow parents' guidelines for feeding their children. If you feel uncomfortable with how parents are feeding their children, talk to them about it and call the nutrition information resource listed in the front of this book.

CHILD NUTRITION AND HEALTH CAMPAIGN

MODEL BEHAVIOR

- ***Schedule meals and snacks.*** Avoid casual snacking that can lead to weight problems.
- ***Eliminate interference.*** Turn the television off during meals.
- ***Create a pleasant atmosphere for eating.*** Include everyone in the conversation.
- ***Sit down and eat with children.*** You can't be a role model if you aren't there.
- ***Practice good table manners.*** Compliment children when they do it right, rather than nagging them about mistakes. Thank the cook(s) before being excused.
- ***Eat the same food the children eat,*** unless there is a reason why you can't. Explain the reason to the children.
- ***Prepare and serve a variety of foods*** that look and taste good.
- ***Be aware of portion sizes.*** Give children small portions, and assure them they can have more if they want.
- ***No one needs to finish everything on his or her plate.*** Allow children to choose what and how much to eat. Respect individual taste preferences. Restricting favorite foods can cause anxiety and lead to overeating if the child fears being deprived of food.
- ***Place no special merit on the dessert.*** Dessert is not a reward for eating "what's good for you."

Source: *The American Dietetic Association/Foundation and Kellogg Company*

FAMILY-STYLE MEAL SERVICE

Family-style meal service means serving foods in bowls or dishes on the table. Children are encouraged to serve themselves or serve themselves with help from an adult.

Enough food must be placed on the table to provide the full required portion size for all the children at the table

INTRODUCING FOODS

BIRTH	Breast milk or iron-fortified infant formula throughout the first year.	Breast milk and formula meets all of the infant's nutritional needs until 4-6 months
4-6 MONTHS	Infant cereal: rice, oatmeal, or barley; feed by a spoon.	Introduce iron-fortified rice cereal. Mix with breast milk or iron-fortified infant formula and feed from a spoon. Don't put cereal or other solids in the baby's bottle. Introduce one new food at a time. Allow a week for each new food. Watch for problems that may be allergy related, such as diarrhea, gas, intestinal discomfort, constipation, hives, rashes, or excessive spitting up.
6-8 MONTHS	Vegetables and fruits, strained/blended; fruit juice from a cup.	Offer strained/blended fruit and vegetables and progress to thicker, lumpier foods. The purpose of introducing foods at this time is to expose the infant to new flavors and textures, especially those high in vitamins A and C. Offer the new food in the morning or early afternoon. Begin with just 1-2 tsp of a new food. Put infant in a high chair facing you, hold the spoon about 12 inches away from the infant's mouth and wait for it to open. Feed as slowly or as fast as infant wants and never force an infant to eat. If they don't like a food, don't push it. Try it again in a few weeks. During this time, 100 percent fruit juice may begin being offered from a cup, but only after the infant has been given the opportunity to eat the above foods. Juice should only be served as part of a meal or snack, and it is recommended to dilute the juice with two parts water. Only 4 total ounces of juice should be offered daily. Whole fruits that have been mashed or pureed are the best option.



Chapter 5 **Nutrition and Physical Activity**

7-10 MONTHS	Protein foods: strained meats, chicken, fish, beans, egg yolk. Other infant cereals. Wheat, mixed grains (around 8 months). Mashed fruits and vegetables. Begin offering finger foods at around 8 months. Toast squares; Cheerios, Kix, Toasted Oat Rings; cooked vegetables; peeled, soft fruit wedges or slices; small tender pieces of meat.	Begin offering small amounts of plain strained meats, increasing the amount and texture gradually. Do not leave a child alone with finger foods – these may cause choking. See list of foods below that cause choking. Give egg yolks at 8-9 months.
10-12 MONTHS	Food from family table (feeds self). Cooked vegetables and soft pieces of fruit. Cereal, breads; cooked beans; small pieces of fish, meats, chicken; mild cheese, yogurt; casseroles.	Babies will start feeding themselves by picking up food with their fingers. Expect the baby to be very messy during this stage.
ONE YEAR	Can drink whole milk from cup (buy Vitamin D fortified) and eat other milk products. Whole egg (yolk only before 1 year of age).	The first year of life is a period of rapid growth. You may notice the baby's appetite drops off at this time. He/she may seem to have many likes and dislikes. Offer small amounts of a variety of good foods. Do not force a child to eat more than wanted. Remember that all babies are different and, like adults, they differ in how much they will eat.

SPECIAL NOTES**Honey**

Honey should never be given to infants under 1 year of age. It can lead to a very serious disease, “infant botulism,” that can even be fatal. Avoid honey in any form during the baby’s first year. Honey is all right for children over the age of 1 and for adults.

FOODS THAT MAY CAUSE CHOKING

Don’t offer these foods to children under 3 years old **unless you have modified them** to reduce the risk of choking.

hot dogs*	grapes*	raisins	nuts
hard candy	seeds	pickles*	corn
thick, sticky cheese food	popcorn	peanut butter	olives

raw vegetables and fruit, including carrots and celery

** If foods such as hot dogs, whole pickles, grapes, etc., are served, cut lengthwise or quarter. Always supervise children while they eat and insist they sit while eating.*

FOOD ALLERGIES

Special attention must be paid to children with food allergies. It is important that written instructions for foods to avoid and appropriate substitutes are posted for children with food allergies.

USDA CHILD AND ADULT CARE FOOD PROGRAM PARTICIPANTS

For participants in the USDA Child and Adult Care Food Program (CACFP), the USDA meal patterns must be used. Through CACFP more than 3.2 million children receive nutritious meals and snacks each day as part of the child care they receive.

Reimbursable meals served to infants, children or adult participants in the Child and Adult Care Food Program shall contain **(as a minimum)** the indicated meal pattern quantities and food components.

Water Availability in the Child Care Food Program

In the Healthy, Hunger-Free Kids Act of 2010, Section 221, a new provision was added to the Russell National School Lunch Act (42 U.S.C. 1766[u]). This new provision requires child care centers, family day care homes, at-risk after-school programs and shelters participating in CACFP to make drinking water available to children, as nutritionally appropriate. Throughout the day, including at meal times, water should be made available to children to drink upon their request. It does not have to be available for children to self-serve. While drinking water must be made available to children during meal times, it is not part of the reimbursable meal and may not be served instead of fluid milk.

USDA INFANT CARE MEAL PATTERN

Meals served to infants, ages birth through 11 months, must meet the requirements described in this meal pattern. Foods included in the infant meal must be of a texture and a consistency that are appropriate for the age of the infant being served. Either breast milk or iron-fortified infant formula must be served for the entire first year.



USDA INFANT CARE MEAL PATTERN

Age	Breakfast	Lunch or Supper	Snack
Birth through 3 months	4-6 fluid ounces breast milk* or formula**	4-6 fluid ounces breast milk* or formula**	4-6 fluid ounces breast milk* or formula**
4 months through 7 months	4-8 fluid ounces breast milk* or formula** 0-3 tablespoons infant cereal***	4-8 fluid ounces breast milk* or formula** and 0-3 tablespoons infant cereal*** and 0-3 tablespoons fruit or vegetable or both	4-6 fluid ounces breast milk* or formula**
8 months up to first birthday	6-8 fluid ounces breast milk* or formula** and 2-4 tablespoons infant cereal and 1-4 tablespoons fruit and/or vegetable or both	6-8 fluid ounces breast milk* or formula** and 2-4 tablespoons infant cereal*** and/or 1-4 tablespoons meat, fish, poultry, egg yolk, or cooked dry beans or peas, or 1/2-2 ounces cheese, or 1-4 tablespoons cottage cheese, cheese food or cheese spread and 1-4 tablespoons fruit or vegetable or both	2-4 fluid ounces breast milk* or formula** or fruit juice**** and 0-1/2 slice bread or 0-2 crackers*****

*It is recommended that breast milk be served in place of formula from birth through 11 months. For some breast-fed infants who regularly consume less than the minimum amount of breast milk per feeding, a serving of less than the minimum amount of breast milk may be offered, with additional breast milk offered if the infant is still hungry.

**Iron-fortified infant formula

***Iron-fortified dry infant cereal

****Full-strength fruit juice

*****Made from whole-grain or enriched meal or flour



CHILD CARE MEAL PATTERN

BREAKFAST Select All Three Components	CHILDREN 1-2 YEARS	CHILDREN 3-5 YEARS	CHILDREN¹ 6-12 YEARS
1 milk fluid milk	$\frac{1}{2}$ cup	$\frac{3}{4}$ cup	1 cup
1 fruit/vegetable juice ² , fruit and/or vegetable	$\frac{1}{4}$ cup	$\frac{1}{2}$ cup	$\frac{1}{2}$ cup
1 grain/bread ³ bread or cornbread or biscuit or roll or muffin or cold dry cereal or hot cooked cereal or pasta or noodles or grains	$\frac{1}{2}$ slice $\frac{1}{2}$ serving $\frac{1}{4}$ cup $\frac{1}{4}$ cup $\frac{1}{4}$ cup	$\frac{1}{2}$ slice $\frac{1}{2}$ serving $\frac{1}{3}$ cup $\frac{1}{4}$ cup $\frac{1}{4}$ cup	1 slice 1 serving $\frac{3}{4}$ cup $\frac{1}{4}$ cup $\frac{1}{2}$ cup
SNACK (Midmorning or Mid-afternoon) Select Two of the Four	CHILDREN 1-2 YEARS	CHILDREN 3-5 YEARS	CHILDREN¹ 6-12 YEARS
1 milk fluid milk	$\frac{1}{2}$ cup	$\frac{1}{2}$ cup	1 cup
1 fruit/vegetable juice, ² fruit and/or vegetable	$\frac{1}{2}$ cup	$\frac{1}{2}$ cup	$\frac{3}{4}$ cup
1 grain/bread ³ bread or cornbread or biscuit or roll or muffin or cold dry cereal or hot cooked cereal or pasta or noodles or grains	$\frac{1}{2}$ slice $\frac{1}{2}$ serving $\frac{1}{4}$ cup $\frac{1}{4}$ cup $\frac{1}{4}$ cup	$\frac{1}{2}$ slice $\frac{1}{2}$ serving $\frac{1}{3}$ cup $\frac{1}{4}$ cup $\frac{1}{4}$ cup	1 slice 1 serving $\frac{3}{4}$ cup $\frac{1}{2}$ cup $\frac{1}{2}$ cup
1 meat/meat alternate meat or poultry or fish ⁴ or alternate protein product or cheese or egg ⁵ or cooked dry beans or peas or peanut or other nut or seed butters or nuts and/or seeds or yogurt	$\frac{1}{2}$ oz. $\frac{1}{2}$ oz. $\frac{1}{2}$ oz. $\frac{1}{2}$ $\frac{1}{3}$ cup 1 Tbsp. $\frac{1}{2}$ oz. 2 oz.	$\frac{1}{2}$ oz. $\frac{1}{2}$ oz. $\frac{1}{2}$ oz. $\frac{1}{2}$ $\frac{1}{3}$ cup 1 Tbsp. $\frac{1}{2}$ oz. 2 oz.	1 oz. 1 oz. 1 oz. $\frac{1}{2}$ $\frac{1}{4}$ cup 2 Tbsp. 1 oz. 4 oz.

LUNCH OR SUPPER Select All Four Components	CHILDREN 1-2 YEARS	CHILDREN 3-5 YEARS	CHILDREN¹ 6-12 YEARS
1 milk fluid milk	1/2 cup	3/4 cup	1 cup
2 fruits/vegetables juice ² , fruit and/or vegetable	1/4 cup	1/2 cup	3/4 cup
1 grain/bread ³ bread or cornbread or biscuit or roll or muffin or cold dry cereal or hot cooked cereal or pasta or noodles or grains	1/2 slice 1/2 serving 1/4 cup 1/4 cup 1/4 cup	1/2 slice 1/2 serving 1/3 cup 1/4 cup 1/4 cup	1 slice 1 serving 1/2 cup 1/2 cup 1/2 cup
1 meal/meal alternate meat or poultry or fish ⁴ or alternate protein product or cheese or egg ⁵ or cooked dry beans or peas or peanut or other nut or seed butters or nuts and/or seeds or yogurt ⁶	1 oz. 1 oz. 1 oz. 1/2 1/4 cup 2 Tbsp. 1/2 oz. 4 oz.	1 1/2 oz. 1 1/2 oz. 1 1/2 oz. 3/4 1/3 cup 3 Tbsp. 3/4 oz. 6 oz.	2 oz. 2 oz. 2 oz. 1 1/2 cup 4 Tbsp. 1 oz. 8 oz.

Notes

¹ Children age 12 and older may be served larger portions based on their greater food needs. They may not be served less than the minimum quantities listed in this column.

² Fruit or vegetable juice must be full strength. Juice cannot be served when milk is the only other snack component.

³ Breads and grains must be made from whole-grain or enriched meal or flour. Cereal must be whole grain or enriched or fortified.

⁴ A serving consists of the edible portion of cooked lean meat or poultry or fish.

⁵ One-half egg meets the required minimum amount (one ounce or less) of meat alternate.

⁶ Yogurt may be plain or flavored, unsweetened or sweetened.

Source: www.fns.usda.gov/cnd/Care/ProgramBasics/Meals



Chapter 5 Nutrition and Physical Activity

SOURCES OF VITAMIN A		
Best Sources	Good Sources	OK Sources
carrot liver pumpkin sweet potatoes winter squash whole milk products	apricot broccoli cantaloupe dark green lettuce greens mango mixed vegetables peas and carrots spinach tomato paste	mandarin oranges peaches tomato tomato soup tomato sauce

SOURCES OF VITAMIN C		
Best Sources	Good Sources	OK Sources
broccoli brussels sprouts cantaloupe cauliflower Chinese pea pods cranberry juice cocktail grapefruit or grapefruit juice kale kiwi kohlrabi lemon mandarin oranges mango orange or orange juice papaya strawberries sweet peppers tangerine vegetable juice cocktail	asparagus blackberries bok choy cabbage greens (collard, mustard or turnip) honeydew melon pineapple fruit or juice raspberries peas potatoes, baked spinach sweet potato, baked swiss chard tomato tomato sauce turnip	blueberries cherries peas and carrots watermelon

SOURCES OF IRON		
oysters liver blackstrap molasses	beef/pork cereal* cooked dry beans** egg gingerbread peanuts and peanut butter spinach tofu tuna	beet greens bran muffin enriched rice or noodles chard hot dog lentils peas poultry prunes or prune juice raisins tahini tortilla

* Some cold cereals are fortified with iron, making them excellent iron sources. Read the label to determine which cereals are iron fortified.

** Remember to combine nonmeat sources of iron with vitamin C foods to increase the absorption of iron from the meal.

SAMPLE MENU FOR CHILDREN USING “MY PLATE”

Serving sizes vary per age. Offer planned meals and snacks to children and allow them to have as much or as little of the planned meal or snack as they want.

BREAKFAST

cornflakes and milk
banana
orange juice

SNACK

pudding made w/milk***
graham crackers
water

LUNCH

turkey sandwich
broccoli with cheese
corn
apple wedges
milk

SNACK*

peanut butter cookies
water**

SUPPER

baked chicken
macaroni and cheese
carrots
roll
chocolate milk

SNACK

cheese toast
water

The menu above provides servings of foods from all food groups.

Breads, Cereals, Rice and Pasta – at least 6 servings

Vegetables – at least 3 servings

Fruits – at least 3 servings

Milk – at least 4 servings

Meat – at least 2 servings

According to USDA/CACFP Guidelines

*One food component is missing; it can be chosen from any of the food groups.

**Water is highly recommended but does not constitute a food component.

***Pudding does not meet the definition of *fluid milk*. The CACFP requirement is for *fluid milk* only

PHYSICAL ACTIVITY

Obesity in Arkansas and the nation is high. The prevalence of obesity continues to be an issue for children across the United States. Nationally, almost one of every five children is considered obese, and 38 percent of Arkansas children are overweight or obese, according to the Natural Wonders Partnership Council (a group of organizational partners involved in children's issues convened by Arkansas Children's Hospital to address the critical health issues of children in Arkansas).

Source: <http://www.archildrens.org/documents/News/NatWon-report-2011.pdf>

Physical activity reduces the risk of obesity in adults and children. Studies have shown that children who are overweight and obese are likely to remain obese and have been associated with cardiovascular disease and diabetes later in their lives.¹ Regular physical activity in childhood and adolescence improves strength and endurance, helps build healthy bones and muscles, helps control weight, reduces anxiety and stress, increases self-esteem, and may improve blood pressure and cholesterol levels.

The lack of safe and available play areas, watching too much television and using electronic-type games instead of body-moving activities are causing more and more children to limit or avoid physical activity. The easy access to high-calorie fast foods and the time, cost and preparation involved in the serving of healthy, nutritious meals and snacks by parents or guardians combined with the children's lack of physical activity all contribute to increasing weight gains by children as well as adults.

Each child care center must be in compliance with the minimum licensing standards related to nutrition and physical activity.

BABIES

Babies develop at their own pace, so it's impossible to tell exactly when a child will learn a given skill. The developmental milestones listed below will give you a general idea of the changes you can expect, but don't be alarmed if your own baby's development takes a slightly different course. A baby's physical development usually begins around 3 months. At this age, babies are able to raise¹ their head and chest when lying on their stomach, able to support upper body with arms, stretch legs out and kick, and are able to push down on legs when feet are placed on a firm surface.

7 to 12 Months

At 7 months, babies will begin to support their whole weight on their legs, and within the next 12 months babies will be able to pull themselves up and able to walk alone or using furniture.²

It may seem complicated for newborns and infants (0 - 3 months) to receive their share of physical activity. At this age, physical activity mostly relates to crib time and screen time. Screen time should be limited to two hours per week, and those hours should be used for educational videos. Out-of-crib time should be used as critical child and physical development time. Infants should spend “play time” on their belly and be encouraged to crawl about three hours per day.³

Your child should be allowed to develop motor skills with challenging toys for his or her age and should interact socially and emotionally with other children.

1 to 2 Years

From 1-1½ years, your child’s muscle skills may include these activities: walks well by self, stoops for an object, walks backwards and climbs stairs, turns pages of a book, stacks a few blocks, begins interest in scribbling, holds cup and eats with spoon (however, may still be clumsy with it.) From 1½-2 years, your child should use large muscles better (running, climbing, throwing, jumping), stack more blocks, copy a straight line, kick and throw a ball, gain more control over bladder and bowel movements, and possibly be able to pedal a tricycle.

3 to 5 Years

Children (3-5) will develop motor and social skills more during preschool years. Programs such as SPARK provide online lesson plans and training for preschool teachers to assist in making their classrooms more physically active. Go to www.sparkpe.org/ for more information and to find ways to make SPARK a part of your child’s lesson plan.⁴



6 to 17 Years

Children ages 6-17 should participate in 60 minutes of aerobic activity each day. This can include either moderate-intensity aerobic activity, such as brisk walking, or vigorous-intensity activity, such as running. Include muscle and bone strengthening activities, such as gymnastics, push-ups or jumping rope at least three days per week as part of your child’s 60 or more minutes.⁵

¹ <http://www.time.com/time/health/article/0,8599,1735638,00.html>

² <http://www.cdc.gov/ncbddd/actearly/milestones/milestones-1yr.html>

³ http://www.nccor.org/newsletters/enewsletter_2011_august.html#news_4

⁴ www.sparkpe.org/

⁵ <http://www.cdc.gov/physicalactivity/everyone/guidelines/children.html#>






THERAPEUTIC DIET MODIFICATION & ALLERGY STATEMENT

Sample Form

THERAPEUTIC DIET MODIFICATION AND ALLERGY STATEMENT	
CHILD'S NAME	PARENT'S NAME
SIGNATURE OF PARENT (FOR PERMISSION TO RELEASE INFORMATION)	
NATURE OF THERAPEUTIC DIETARY MODIFICATION	
NATURE OF ALLERGY	
FOODS CHILD IS ALLERGIC TO	SUBSTITUTE FOODS
HEALTH CARE PROVIDER NAME AND ADDRESS	
HEALTH CARE PROVIDER SIGNATURE	DATE




SEQUENCE OF INFANT DEVELOPMENT AND FEEDING SKILLS IN NORMAL, HEALTHY FULL-TERM INFANTS

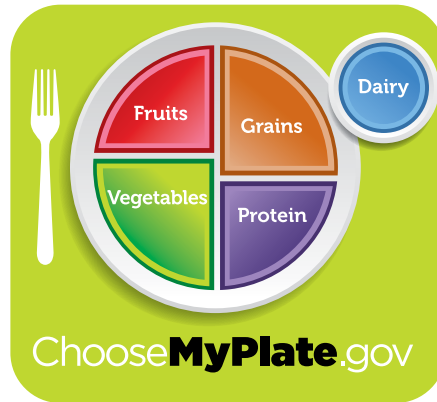
DEVELOPMENTAL SKILLS

Baby's Approx. Age	Mouth Patterns	Head and Body Skills	Feeding Skills or Abilities
Birth through 5 months 	<ul style="list-style-type: none"> • Suck/swallow reflex • Tongue thrust reflex • Rooting reflex • Gag reflex 	<ul style="list-style-type: none"> • Poor control of head, neck, trunk • Brings hands to mouth around 3 months 	<ul style="list-style-type: none"> • Swallows liquids but pushes most solid objects from the mouth
4 months through 6 months 	<ul style="list-style-type: none"> • Draws in upper or lower lip as spoon is removed from mouth • Up-and-down munching movement • Can transfer food from front to back of tongue to swallow • Tongue thrust and rooting reflexes begin to disappear • Gag reflex diminishes • Opens mouth when sees spoon approaching 	<ul style="list-style-type: none"> • Sits with support • Good head control • Uses whole hand to grasp objects (palmer grasp) 	<ul style="list-style-type: none"> • Takes in a spoonful of pureed or strained food and swallows it without choking • Drinks small amounts from cup when held by another person, with spilling
5 months through 9 months 	<ul style="list-style-type: none"> • Begins to control the position of food in the mouth • Up-and-down munching movement • Positions food between jaws for chewing 	<ul style="list-style-type: none"> • Begins to sit alone unsupported • Follows food with eyes • Begins to use thumb and index finger to pick up objects (pincer grasp) 	<ul style="list-style-type: none"> • Begins to eat mashed foods • Eats from a spoon easily • Drinks from a cup with some spilling • Begins to feed self with hands
8 months through 11 months 	<ul style="list-style-type: none"> • Moves food from side to side in mouth • Begins to curve lips around rim of cup • Begins to chew in rotary pattern (diagonal movement of the jaw as food is moved to the side or center of the mouth) 	<ul style="list-style-type: none"> • Sits alone easily • Transfers objects from hand to mouth 	<ul style="list-style-type: none"> • Begins to eat ground or finely chopped food and small pieces of soft food • Begins to experiment with spoon but prefers to feed self with hands • Drinks from a cup with less spilling
10 months through 12 months 	<ul style="list-style-type: none"> • Rotary chewing (diagonal movement of the jaw as food is moved to the side or center of the mouth) 	<ul style="list-style-type: none"> • Begins to put spoon in mouth • Begins to hold cup • Good eye-hand-mouth coordination 	<ul style="list-style-type: none"> • Eats chopped food and small pieces of soft, cooked table food • Begins self-spoon feeding with help

FEEDING THE BABY FOR THE FIRST YEAR

Babies grow quickly during the first year of life and make many changes in the types of foods and textures of foods they are able to eat. As babies grow and develop, watch for the following signs, which will tell you when they are ready for a new food.

Baby's Age	When Babies Can:	Serve:
Birth through 3 months 	<ul style="list-style-type: none"> Only suck and swallow 	LIQUIDS ONLY <ul style="list-style-type: none"> Breast milk Infant formula with iron
4 months through 7 months 	<ul style="list-style-type: none"> Draw in upper or lower lip as spoon is removed from mouth Move tongue up and down Sit up with support Swallow semisolid foods without choking Open the mouth when they see food Drink from a cup with help, with spilling 	ADD SEMISOLID FOODS <ul style="list-style-type: none"> Infant cereal with iron Strained vegetables* Strained fruit* <p>*may be started later in the age range</p>
8 months through 11 months 	<ul style="list-style-type: none"> Move tongue from side to side Begin spoon feeding themselves with help Begin to chew and have some teeth Begin to hold food and use their fingers to feed themselves Drink from a cup with help, with less spilling 	ADD MODIFIED TABLE FOODS <ul style="list-style-type: none"> Mashed or diced soft fruit Mashed or soft-cooked vegetables Mashed egg yolk Strained meat/poultry Mashed cooked beans or peas Cottage cheese, yogurt or cheese strips Pieces of soft bread Crackers Breast milk, iron-fortified formula or fruit juice in a cup



MYPLATE ICON

MyPlate is part of a larger communications initiative based on *2010 Dietary Guidelines for Americans* to help consumers make better food choices.

MyPlate is designed to *remind* Americans to eat healthfully; it is not intended to change consumer behavior alone.

MyPlate illustrates the five food groups using a familiar mealtime visual, a place setting.

Balancing Calories

- Enjoy your food, but eat less.
- Avoid oversized portions.

Foods to Increase

- Make half your plate fruits and vegetables.
- Make at least half your grains whole grains.
- Switch to fat-free or low-fat (1%) milk.

Foods to Reduce

- Compare sodium in foods such as soup, bread and frozen meals – and choose the foods with lower numbers.
- Drink water instead of sugary drinks.

**10
tips**

**Nutrition
Education Series**

choose MyPlate

10 tips to a great plate



Making food choices for a healthy lifestyle can be as simple as using these 10 Tips.

Use the ideas in this list to *balance your calories*, to choose foods to *eat more often*, and to cut back on foods to *eat less often*.

1 balance calories

Find out how many calories YOU need for a day as a first step in managing your weight. Go to www.ChooseMyPlate.gov to find your calorie level. Being physically active also helps you balance calories.

2 enjoy your food, but eat less

Take the time to fully enjoy your food as you eat it. Eating too fast or when your attention is elsewhere may lead to eating too many calories. Pay attention to hunger and fullness cues before, during, and after meals. Use them to recognize when to eat and when you've had enough.



3 avoid oversized portions

Use a smaller plate, bowl, and glass. Portion out foods before you eat. When eating out, choose a smaller size option, share a dish, or take home part of your meal.

4 foods to eat more often

Eat more vegetables, fruits, whole grains, and fat-free or 1% milk and dairy products. These foods have the nutrients you need for health—including potassium, calcium, vitamin D, and fiber. Make them the basis for meals and snacks.



5 make half your plate fruits and vegetables

Choose red, orange, and dark-green vegetables like tomatoes, sweet potatoes, and broccoli, along with other vegetables for your meals. Add fruit to meals as part of main or side dishes or as dessert.

6 switch to fat-free or low-fat (1%) milk

They have the same amount of calcium and other essential nutrients as whole milk, but fewer calories and less saturated fat.



7 make half your grains whole grains

To eat more whole grains, substitute a whole-grain product for a refined product—such as eating whole-wheat bread instead of white bread or brown rice instead of white rice.

8 foods to eat less often

Cut back on foods high in solid fats, added sugars, and salt. They include cakes, cookies, ice cream, candies, sweetened drinks, pizza, and fatty meats like ribs, sausages, bacon, and hot dogs. Use these foods as occasional treats, not everyday foods.

9 compare sodium in foods

Use the Nutrition Facts label to choose lower sodium versions of foods like soup, bread, and frozen meals. Select canned foods labeled “low sodium,” “reduced sodium,” or “no salt added.”



10 drink water instead of sugary drinks

Cut calories by drinking water or unsweetened beverages. Soda, energy drinks, and sports drinks are a major source of added sugar, and calories, in American diets.



Go to www.ChooseMyPlate.gov for more information.

DG TipSheet No. 1

June 2011

USDA is an equal opportunity provider and employer.

**10
tips**
Nutrition
Education Series

kid-friendly veggies and fruits



10 tips for making healthy foods more fun for children

Encourage children to eat vegetables and fruits by making it fun. Provide healthy ingredients and let kids help with preparation, based on their age and skills. Kids may try foods they avoided in the past if they helped make them.

1 smoothie creations

Blend fat-free or low-fat yogurt or milk with fruit pieces and crushed ice. Use fresh, frozen, canned, and even overripe fruits. Try bananas, berries, peaches, and/or pineapple. If you freeze the fruit first, you can even skip the ice!



2 delicious dippers

Kids love to dip their foods. Whip up a quick dip for veggies with yogurt and seasonings such as herbs or garlic. Serve with raw vegetables like broccoli, carrots, or cauliflower. Fruit chunks go great with a yogurt and cinnamon or vanilla dip.



3 caterpillar kabobs

Assemble chunks of melon, apple, orange, and pear on skewers for a fruity kabob. For a raw veggie version, use vegetables like zucchini, cucumber, squash, sweet peppers, or tomatoes.

4 personalized pizzas

Set up a pizza-making station in the kitchen. Use whole-wheat English muffins, bagels, or pita bread as the crust. Have tomato sauce, low-fat cheese, and cut-up vegetables or fruits for toppings. Let kids choose their own favorites. Then pop the pizzas into the oven to warm.

5 fruity peanut butterfly

Start with carrot sticks or celery for the body. Attach wings made of thinly sliced apples with peanut butter and decorate with halved grapes or dried fruit.

6 frosty fruits

Frozen treats are bound to be popular in the warm months. Just put fresh fruits such as melon chunks in the freezer (rinse first). Make "popsicles" by inserting sticks into peeled bananas and freezing.

7 bugs on a log

Use celery, cucumber, or carrot sticks as the log and add peanut butter. Top with dried fruit such as raisins, cranberries, or cherries, depending on what bugs you want!

8 homemade trail mix

Skip the pre-made trail mix and make your own. Use your favorite nuts and dried fruits, such as unsalted peanuts, cashews, walnuts, or sunflower seeds mixed with dried apples, pineapple, cherries, apricots, or raisins. Add whole-grain cereals to the mix, too.

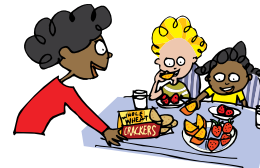


9 potato person

Decorate half a baked potato. Use sliced cherry tomatoes, peas, and low-fat cheese on the potato to make a funny face.

10 put kids in charge

Ask your child to name new veggie or fruit creations. Let them arrange raw veggies or fruits into a fun shape or design.



Chapter 5 Nutrition and Physical Activity

GETTING STARTED WITH MYPLATE

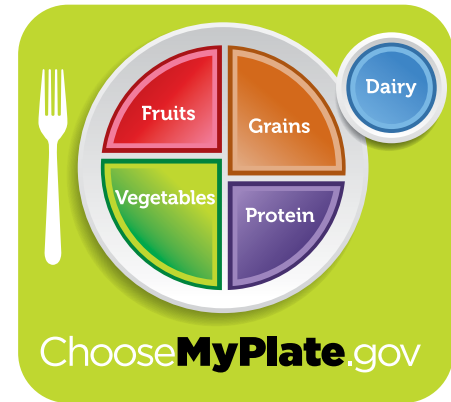
ChooseMyPlate.gov

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CHOOSEMYPLATE.GOV

The website features practical information and tips to help Americans build healthier diets.

It features selected messages to help consumer focus on key behaviors. Selected messages include:

Balancing Calories

- Enjoy your food, but eat less.
- Avoid oversized portions.

Foods to Increase

- Make half your plate fruits and vegetables.
- Make at least half your grains whole grains.
- Switch to fat-free or low-fat (1%) milk.



Foods to Reduce

- Compare sodium in foods such as soup, bread and frozen meals – and choose foods with lower numbers.
- Drink water instead of sugary drinks.
- Choose **MyPlate.gov** includes much of the consumer and professional information formerly found on MyPyramid.gov.

CONSUMER RESOURCES

Let's Eat for the Health of It

The 2010 Dietary Guidelines brochure

This brochure contains practical strategies to make healthy food choices. The brochure highlights themes from the guidelines such as *Balancing Calories*, *Foods to Reduce* and *Foods to Increase*. This resource is available online as a PDF, and print copies will be available in the near future.



10 TIPS SERIES

The 10 Tips Nutrition Education Series provides consumers and professionals with easy-to-follow tips in a convenient, printable format. Educators can use these to support existing lessons, and consumers can choose one or more of these tip sheets to start making small changes toward healthier eating. These and many other printable items are available in Spanish.

- 1) Choose MyPlate
- 2) Add more vegetables to your day
- 3) Focus on fruits
- 4) Make half your grains whole
- 5) Got your dairy today?
- 6) With protein foods, variety is key
- 7) Build a healthy meal
- 8) Healthy eating for vegetarians
- 9) Smart shopping for veggies and fruits
- 10) Liven up your meal with vegetables and fruits
- 11) Kid-friendly veggies and fruits
- 12) Be a healthy role model for children
- 13) Cut back on your kid's sweet treats
- 14) Salt and sodium



Chapter 5 Nutrition and Physical Activity

ALSO ON THE WEB

- Sample menus for a week
- Food-group-based recipes
- Historical development of food guidance
- Nutrition communicators network for partners
- Application forms
- All print-ready content

Cucumber Yogurt Dip

Serving Size: 1/6 of recipe
Yield: 6 servings

Ingredients:
2 large cucumbers
2 cups plain yogurt, low-fat
1/2 cup sour cream, non-fat
1 tablespoon lemon juice
1 tablespoon fresh dill

Color	Food Group	Amount
Orange	Grains	—
Green	Vegetables	1 1/2 c
Red	Fruits	—
Blue	Dairy	1/2 c
Purple	Protein	0

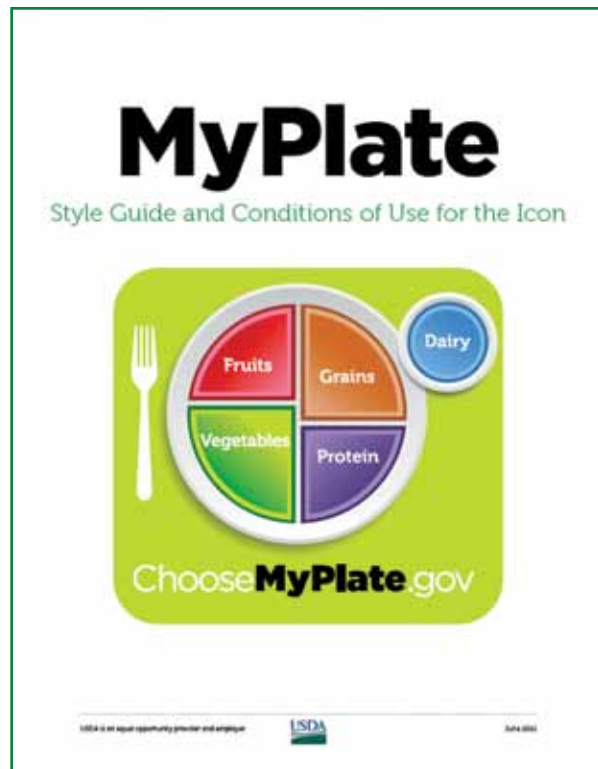
Nutrient Totals
Per Serving:
Calories 100
Total Fat 1.5 g
Saturated Fat 1 g
Sodium 120 mg
Protein 6 g

Chill for 1 hour.

Sample Menus for a 2000 Calorie Food Pattern

MYPLATE STYLE GUIDE

USDA encourages the use of the MyPlate icon in a variety of applications, including textbooks and other educational materials. Any educator or consumer interested in using the image should refer to this guide for all appropriate use information.



January 2012
Center for Nutrition
Policy and Promotion



ARKANSAS HEALTHY CHILDREN HANDBOOK

6TH EDITION • 2012

Chapter 6 WIC (Women, Infants and Children)

Chapter Content

Purpose and Eligibility

Live in Arkansas

Meet Income Guidelines

Are Nutritionally Eligible

Foods Provided to Children and Women

Foods Provided to Infants

Funding

WIC Income Eligibility Guidelines



**ARKANSAS DEPARTMENT OF
HUMAN SERVICES**



Division of Child Care and Early Childhood Education

Chapter 6 **WIC (Women, Infants and Children)**

PURPOSE AND ELIGIBILITY

The purpose of the Arkansas WIC Program (Special Supplemental Nutrition Program for Women, Infants and Children) is to improve the nutrition of eligible pregnant, breast-feeding and postpartum women, infants and young children to age 5 during periods of critical growth by directly supplementing their diets with foods rich in nutrients they need, providing nutrition education and counseling, breast-feeding support and referrals to other services.

The program provides checks for specific foods that participants redeem at local authorized grocery stores. Women and children participants are also provided Cash Value Benefits (CVBs) that are redeemed for fresh and/or frozen fruits and vegetables.

Pregnant, breast-feeding and postpartum women, infants and children under age 5 are eligible for WIC if they:

- **LIVE IN ARKANSAS.** There is no waiting period to meet the residency requirement.
 - **MEET INCOME GUIDELINES.** These guidelines are set at 185 percent of poverty and are revised annually. The revised income guidelines must be implemented by July 1 each year. The guidelines are used by a number of Federal programs as the basis for determining and updating program income eligibility limits. For the WIC Income Eligibility Guidelines effective for July 1, 2012 to June 30, 2013, you may check the website for the current guidelines: <http://www.fns.usda.gov/wic/howtoapply/incomguidelines12-13.htm>.
- Applicants must report household income. Recipients of Medicaid, TEA or SNAP (formerly Food Stamps) are automatically income eligible for WIC. Documentation of current eligibility for one of these programs is sufficient proof of income eligibility.
- **ARE NUTRITIONALLY ELIGIBLE.** Conditions such as anemia; certain medical disorders; weight (underweight, overweight, pattern of gain or loss; weight in relation to height; etc.); number and frequency of pregnancies and inadequate diet are some of the factors considered in a nutritional assessment. This assessment is performed by a nurse, nutritionist or physician in the Local (County) Health Unit.



**WIC is available in every Arkansas county at
local (county) health units, satellite clinics or WIC-only clinics**

Chapter 6 **WIC (Women, Infants and Children)**

FOODS PROVIDED TO CHILDREN AND WOMEN

- Milk
- Soy-based Beverages
- Cheese
- Iron-fortified Cereals
- Dried/Canned Beans and Peas
- Fresh or Frozen Fruits and Vegetables
- Whole Grains
- Juice
- Eggs
- Canned Fish*
- Peanut Butter*

*Issued for specific risk factors or participant types.

FOODS PROVIDED TO INFANTS

- Special food packages for breast feeding mothers
- Iron-fortified infant formula
- Infant cereal at 6 months
- Infant fruits and vegetables at 6 months
- Infant meats at 6 months for exclusively breast-fed infants

FUNDING

WIC is funded by USDA, Food and Nutrition Service, and administered by the Arkansas Department of Health. The Arkansas WIC Program serves eligible applicants without regard to race, color, national origin, age, sex or disability.

**If you would like brochures or posters to inform others
about WIC, please call 501-661-2508.**

**For more information: Call 1-800-235-0002 or visit our website at
www.healthy.arkansas.gov**

WIC is an equal opportunity provider.

Chapter 6 WIC (Women, Infants and Children)

WIC Income Eligibility Guidelines (Effective from July 1, 2012 to June 30, 2013)

48 Contiguous States, D.C., Guam and Territories					
Persons in Family or Household Size	Annual	Monthly	Twice-Monthly	Bi-Weekly	Weekly
1	\$20,665	\$1,723	\$862	\$795	\$398
2	27,991	2,333	1,167	1,077	539
3	35,317	2,944	1,472	1,359	680
4	42,643	3,554	1,777	1,641	821
5	49,969	4,165	2,083	1,922	961
6	57,295	4,775	2,388	2,204	1,102
7	64,621	5,386	2,693	2,486	1,243
8	71,947	5,996	2,998	2,768	1,384
Each Additional Member Add	+\$7,326	+611	+306	+282	+141
Alaska					
Persons in Family or Household Size	Annual	Monthly	Twice-Monthly	Bi-Weekly	Weekly
1	\$25,845	\$2,154	\$1,077	\$995	\$498
2	35,002	2,917	1,459	1,347	674
3	44,160	3,680	1,840	1,699	850
4	53,317	4,444	2,222	2,051	1,026
5	62,475	5,207	2,604	2,403	1,202
6	71,632	5,970	2,985	2,756	1,378
7	80,790	6,733	3,367	3,108	1,554
8	89,947	7,496	3,748	3,460	1,730
Each Additional Member Add	+9,158	+764	+382	+353	+177
Hawaii					
Persons in Family or Household	Annual	Monthly	Twice-Monthly	Bi-Weekly	Weekly
1	\$23,791	\$1,983	\$992	\$916	\$458
2	32,209	2,685	1,343	1,239	620
3	40,626	3,386	1,693	1,563	782
4	49,044	4,087	2,044	1,887	944
5	57,461	4,789	2,395	2,211	1,106
6	65,879	5,490	2,745	2,534	1,267
7	74,296	6,192	3,096	2,858	1,429
8	82,714	6,893	3,447	3,182	1,591
Each Additional Member Add	+8,418	+702	+351	+324	+162

While most states use maximum guidelines, states may set lower income standards. A person or certain family members who participate in other benefits programs such as Supplemental Nutrition Assistance Program, Medicaid or Temporary Assistance for Needy Families automatically meet the income eligibility requirement.



ARKANSAS HEALTHY CHILDREN HANDBOOK

6TH EDITION • 2012

Chapter 7 **Preparing, Handling and Storing Food**

Chapter Content

What Should I Do When Purchasing Food?

What Should I Do Before Preparing Food?

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Honey

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Baby Foods

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Formula

General Food Safety Tips



**ARKANSAS DEPARTMENT OF
HUMAN SERVICES**



Division of Child Care and Early Childhood Education



Chapter 7 **Preparing, Handling and Storing Food**

Preparing, handling and storing food deserves special attention because germs may be spread during these activities. Germs, such as bacteria and viruses, grow quickly in some foods. Food-borne illnesses can cause diarrhea, vomiting, fever and stomach pain. Food that is not properly cooked, cooled or stored can be a perfect place for germs to grow.

WHAT SHOULD I DO WHEN PURCHASING FOOD?

- Make sure food suppliers meet local, state and federal health codes.
- Purchase only meats and poultry that have passed federal inspection.
- Purchase only milk and milk products that are pasteurized.
- Examine all food when it is delivered.
- Make sure that the canned goods are not rusted, leaky or swollen. If they are, throw them away.
- If canned goods are dented at the can's rims or seam, do not use.
- Do not use home-canned goods.

WHAT SHOULD I DO BEFORE PREPARING FOOD?

- Wash hands before, during and after food preparation (and children's hands, if they are helping).
- Cover cuts and burns.
- Do not let people with infected cuts or sores, colds, or other communicable diseases prepare or serve the food.
- Wash the tops of canned goods before opening.
- Wash all raw fruits and vegetables thoroughly before using.
- Thaw frozen foods in the refrigerator or microwave, or run water over them.
- Thaw foods as part of the cooking process; allow extra cooking time.
- Never let food thaw at room temperature.
- Wash all work surfaces with soap, water and a mild disinfectant before and after preparing foods.
- Scrub cutting boards with hot water and detergent, and disinfect with a bleach solution of one tablespoon bleach per gallon of water.



Chapter 7 **Preparing, Handling and Storing Food**

- It is good to have two cutting boards: one for raw poultry and meats, and one for cooked foods and raw vegetables or fruits.
- When cutting boards develop deep cuts that cannot be cleaned and disinfected, they need to be replaced.
- Plastic cutting boards are preferred.
- If children are going on an outing and taking their lunches, choose foods that do not spoil or take an ice chest to keep the food cool and safe.
- **Remember**, foods should be kept hot or cold and spend as little time as possible at room temperature.

NOTE: Two-hour Rule: Do not leave food at room temperature for more than two hours. If in doubt, throw it out!

WHAT SHOULD I DO WHILE PREPARING FOOD?

- When cooking meat, make sure it is cooked all the way through; the internal temperature should be:
 - » Stuffing and poultry – minimum 165°F (Do not cook stuffing in poultry.)
 - » Pork – minimum 150°F.
 - » **Special Note:** Ground beef or anything containing ground beef should be cooked to an internal temperature of 155°F or until all of the pink color is gone and juices run clear.
- Never use the same spoon for tasting and cooking. Each time food is tasted while cooking, change utensils.
- Wash hands, utensils and work surfaces after touching raw meat, poultry or eggs.
- Cover your mouth when coughing or sneezing; wash your hands immediately afterward.

WHAT SHOULD I DO AFTER PREPARING FOOD?

- Foods must be held at safe temperatures:
 - » Cold foods – 40°F or below.
 - » Hot foods – 140°F or above.
 - » Foods held at these temperatures may be reused if heated to 165°F.
- Do not serve food again; the only exceptions are raw fruits that can be washed and packaged foods.
- Provide a serving utensil for each bowl.

- Thoroughly clean all dishes, utensils and work surfaces with soap and water and a mild disinfectant after each use.
- For child care family homes, it is recommended that leftovers be used within 24 hours of original preparation.

HOW DO I STORE FOOD AND NONFOOD ITEMS SAFELY?

- Rotate older cans of food to the front and use them first.
- Store food items separately from nonfood items.
- Put leftover food in the refrigerator; allow for circulation. Store leftovers in well-covered containers above the fresh foods.
- Store raw products lower than other foods, since they have a higher capacity for growth of bacteria.
- Immediately freeze leftovers or use within 24 hours; otherwise, throw away.
- Store unrefrigerated foods in metal, glass or plastic containers.
- Store dry items in an area that is about 50°F to 70°F and moisture free.
- Containers of food should be stored at least 6 inches above the floor.
- Do not store food under the sink.
- Do not store food in cupboards next to the stove; the heat dries up food and encourages insect infestation.
- Do not use pest strips around food areas.
- Store all perishable foods at temperatures that prevent spoilage.
- Refrigerator: 40°F or below.
- Freezer: 0°F or below.
- Check thermometers daily.
- Clean refrigerator with soda or bleach solution weekly.
- Defrost refrigerator before the ice is 1/4-inch thick.
- Wash tables with a mild disinfectant before and after every meal.
- Wash food preparation surfaces between preparations of different items.
- Thoroughly sanitize cutting board before and after cutting any meat, poultry or fish.



FOR CENTERS ONLY:

WHAT SHOULD KITCHEN PERSONNEL DO TO ENSURE FOOD SAFETY?

- Persons preparing food should meet health standards.
- Hairnets should be worn in the kitchen.
- Highly flammable clothing should not be worn while cooking (nylon, tricots and light synthetics).
- Smoking, gum chewing and personal drinks/food should not be allowed in the kitchen.
- Hands should be washed before touching food, between different foods and after using the bathroom, coughing and sneezing.
- No one ill with a bacterial or viral infection should handle food.
- No one with an open or infected injury should work in food preparation unless the injuries are covered with nonporous materials (e.g., latex gloves).

FOODS REQUIRING SPECIAL CARE

HONEY

Honey should never be given to infants under 1 year of age. It can lead to a very serious disease, infant botulism, which can even be fatal. Avoid honey in any form during the baby's first year. Honey is all right for children over the age of 1 and for adults.

FOODS THAT MAY CAUSE CHOKING

Don't offer these foods to children under 3 years old **unless you have modified them** to reduce the risk of choking.

hot dogs*	grapes*	raisins	nuts
hard candy	seeds	pickles*	corn
thick, sticky cheese food	popcorn	peanut butter	olives

raw vegetables and fruit, including carrots and celery)

** If foods such as hot dogs, whole pickles, grapes, etc., are served, cut lengthwise or quarter. Always supervise children while they eat and insist they sit while eating.*

FOOD SAFETY ISSUES FOR INFANTS

BABY FOODS

Baby food in jars can easily spoil and cause illness. When feeding an infant, put the baby food from the jar in a separate bowl or cup. Using a clean spoon, place the amount of food you think the baby will eat into a cup or bowl. Do not directly feed from the jar. If the infant wants more food, always first serve from the jar to the bowl with a clean spoon. Germs from the mouth, if introduced into a jar of food, can cause spoilage. If the infant does not eat the entire serving from the bowl, it should be thrown away, never placed back in the jar.

BREAST MILK

More women are now breast-feeding their babies. The working mother who is breast-feeding may send her infant to child care with bottles of breast milk. Breast milk is obtained by the mother pumping her breasts and putting the milk into a bottle. Breast milk is an excellent source of nourishment for infants. Like formula, it is important to store breast milk carefully so it does not spoil. The following are guidelines for storing breast milk:

- Wash your hands before handling.
- Label bottles of breast milk brought to the center with the child's name, date and time the breast milk was collected.
- Use refrigerated breast milk that has not been frozen within five days after collection.
- Use frozen breast milk that has been thawed within 24 hours.
- Thaw frozen breast milk under cold running water.
- Offer only the amount you think the baby will eat because leftover breast milk cannot be stored and reused.
- Throw away all unused milk after each feeding.
- Use bottles of breast milk only for the baby for whom they are intended.
- Wash skin on which breast milk has spilled with soap and water immediately.



Breast milk may appear thinner, paler or even bluish in color compared to formula. This is normal. If it has been stored properly, it is completely safe and very nutritious for the infant.

FORMULA

- It is important to the infant's health that formula be prepared correctly and stored safely. Procedures concerning formula preparation and storage are written to prevent problems that may be caused by:
 - » Adding too much or too little water.
 - » Not sterilizing the water used to mix with concentrated or powdered formula by bringing cold water to a very bubbly boil, boiling it for 1-2 minutes and then allowing it to cool.
 - » Using tap water without boiling; collect only cold tap water for boiling by letting the cold tap run for two minutes and then collecting the water.
 - » Formula spoiling or not being prepared in a way to keep germs from growing. Spoiled formula can make infants very sick. Germs can get into formula bottles from:
 - The hands, nose or throat of the person preparing the bottle
 - The counter or work area
 - A bottle that was not well cleaned
 - Unclean water used to make formula
 - Formula stored too long
 - A bottle left at room temperature
 - Baby sucking on bottle; saliva enters bottle
- It is important to be very careful about cleanliness when preparing infant formula –
 - » Before preparation, carefully wash hands.
 - » Make sure the kitchen or formula preparation area is very clean.
 - » Thoroughly wash and rinse all equipment to be used, including the cans containing the milk, the bottles and nipples.
 - » If bottles and nipples are to be reused by the facility, they must be sanitized.
 - » Bottles can be sanitized in a commercial dishwasher or by boiling for five minutes.

NOTE: A dishwasher (if not a commercial type) most likely does not sanitize bottles.

- There are health and liability risks when reusing formula. These risks can pose serious health complications. Any formula remaining after feeding should be discarded. Throw out any unused formula or breast milk left in a bottle after feeding. Rinse the bottle in cool water to remove formula.
- To prevent illness from shared bottles or mistakes in giving incorrect formula, label each child's bottles and formula with the child's name and the date the formula was prepared.
- Refrigerate the bottles as soon as they arrive and discard formula after 12 hours.
- Do not use a bottle if it has been out of the refrigerator longer than one hour.

HEATING FORMULA

- We recommend that you **do not use the microwave oven to warm baby bottles** of formula or breast milk.
 - » The primary danger is overheating the liquid, although the bottle itself may remain cool to the touch.
 - » Drinking the hot liquid may burn the baby's mouth or throat.
 - » In addition, the hot liquid forms steam that builds up in the bottle, which may cause the bottle to explode.
- Overheating formula or breast milk may also destroy vitamins. To be on the safe side, heat an infant's milk or food by one of the following methods:
 - » Gently shake the bottle while holding it under running tap water for a few minutes, just long enough to take the chill off.
 - » Set the filled bottle in a bowl of hot, not boiling, water for a few minutes. Crockpots may be used for this purpose and are useful to warm several bottles at once.
- Shake the bottle gently to distribute the warmth evenly. Then shake a few drops from the bottle onto your wrist. If the temperature feels all right to you, it is safe for the infant.
- Warming the bottle this way may take a few minutes longer than using a microwave oven, but it's worth it for the child's safety.

GENERAL FOOD SAFETY TIPS

The best way to prevent germ growth in food is to either keep it hot, 140°F or above, or keep it cold, 40°F or below. The longer the food stays at room temperature, the more likely germs will grow.

Here are some practical tips to keep food safe:

- Place cooked food promptly into the refrigerator. First transfer hot foods into shallow pans or containers, no deeper than 3 inches, so they will cool more quickly. Then place immediately into refrigerator. Refrigerated food must be kept covered to keep particles from falling into it. You may cover hot food after it is cool.
- In the refrigerator, store raw foods on a lower shelf below cooked or ready to eat foods. This will reduce the chance that raw foods could spill and contaminate the ready to eat food.
- Use one of these methods to defrost foods safely:
 - » Place frozen food in the refrigerator to thaw; be sure to place it in the refrigerator well in advance of the time you will need it.
 - » Thaw food under cold running water.
 - » Thaw food as part of the cooking process; be sure to allow longer cooking time.
 - » Thaw food using the defrost setting of a microwave oven.
 - » **NEVER** let food thaw by sitting out at room temperature.
- Keep meat, fish and poultry, milk and egg products refrigerated until immediately before use because they can easily cause food-borne illness.
- Store food in refrigerators and freezers set at safe air temperatures.
- Use a thermometer to check the temperature:
 - » Refrigerator: 32°F - 40° F.
 - » Freezer: Lower than 0°F.
- If children are going on an outing and taking their lunches, choose foods that do not spoil or take an ice chest to keep the food cool and safe.

REMEMBER: Foods should be kept hot or cold and spend as little time as possible at room temperature.

- Care and cleanliness should be stressed in all areas of the center where children eat:
 - » Never place food and utensils (cups, plates, bowls, bottles) on the floor, in the diaper-changing area or in the same sink where hands are washed after diapering or toileting.

- » These are particularly dirty areas where germs can more easily enter and spoil the food.
- Wash, rinse and disinfect tableware and kitchen utensils in the following way:
 - » Wash in the dishwasher, or
 - » Wash with detergent and hot water.
 - 1) Rinse with hot water.
 - 2) Disinfect with a cool bleach solution of 1 tablespoon of bleach per gallon of water.

(Note: This solution is weaker than the one used for disinfecting toys and changing areas.)
 - 3) Air-dry.

NOTE: Child care centers licensed by the Division of Child Care and Early Childhood Education at the Arkansas Department of Human Services and holding an Arkansas Department of Health Day Care Food Service Permit are required to have a three-compartment utensil washing sink. (If a dishwasher is used, it must comply with Chapter 4 of the Health Department regulations.)

- If you cannot wash and disinfect the tableware and utensils then use disposable paper plates, cups, etc., to prepare and serve food. Throw them away after using. (Avoid non-biodegradable foam-type products.)
- Scrub cutting boards with hot water and detergent, and disinfect whenever they are used to cut up raw meat, poultry or fish.
 - » Disinfect with a bleach solution of 1 tablespoon bleach per gallon of water.
 - » Do not cut up vegetables, fruits or cooked foods on the same cutting board that has just been used to cut up raw chicken, fish or meat until the cutting board has been washed and disinfected.
 - » It is a good idea to have two cutting boards: one for raw poultry and meats, and one for cooked foods and raw vegetables or fruits.
 - » When cutting boards develop deep cuts that cannot be cleaned and disinfected, they need to be replaced.

Also see the *Sequence of Infant Development and Feeding Skills in Normal, Healthy Full-Term Infants*. Source: teamnutrition.usda.gov/Resources/feedinginfants-ch2.pdf





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Chapter 8 **Dental Health**

Chapter Content

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Dental Care for Small Children

Care of Toothbrushes

Tooth Decay/Cavities

Pacifiers and Thumb-Sucking

Baby Bottle Tooth Decay

Prevention

How to Break the Habit

Suggestions to Discuss with Parents



ARKANSAS DEPARTMENT OF
HUMAN SERVICES



Division of Child Care and Early Childhood Education

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ARKANSAS HEALTHY CHILDREN HANDBOOK

Chapter 8 **Dental Health**

NORMAL DENTAL HEALTH

The lower two front teeth usually come in at about 6 months of age, although this may vary from 3 - 12 months. All the baby teeth (20 primary teeth) will be in by 2 - 3 years of age. Primary teeth are as important as permanent teeth. Even though baby teeth are replaced by permanent teeth, they are very important to children's appearance, for eating and speaking properly, and, most importantly, they act as guideposts (markers) for proper eruption of permanent teeth. We often blame teething for illness caused by other health problems; teething is normal but can cause some discomfort and fussiness.

DENTAL CARE FOR SMALL CHILDREN

Clean teeth with a clean washcloth or a small, soft toothbrush as soon as the teeth come in. Children in child care should be provided with individual toothbrushes and given time after at least one meal to brush their teeth. Use a fluoridated toothpaste and place a "smear" amount on the brush. Up to the age of five, the adult should brush the child's teeth at least once a day.

If it is not possible to brush after eating, have children rinse out their mouths with water. Rinsing with water helps to clean decay-causing foods from the mouth.

Children should first visit the dentist around 1 year of age and regularly thereafter. However, if a child has any problems in the mouth, a dentist should be seen sooner.



CARE OF TOOTHBRUSHES

When individual toothbrushes are used in child care, precautions must be taken to decrease the risk of spreading disease by improper storage. Do not store toothbrushes in a single container. Individual hooks spaced apart are an acceptable means of storing toothbrushes. Be sure to rinse toothbrushes thoroughly after use.

TOOTH DECAY/CAVITIES

Small children can easily get tooth decay (cavities). Diet plays a central role in the development of tooth decay. Soft drinks or fruit drinks, candy, baby formulas and even "health" foods such as raisins can cause tooth decay. Foods most likely to cause tooth decay are ones that contain sugar and stick to teeth and gums (such as soft candy or raisins).



Chapter 8 **Dental Health**

Tooth decay is a contagious disease. After eruption of a child's teeth has begun, the bacteria that cause decay are generally transmitted from a child's primary caregiver. Mothers with active tooth decay are more likely to transmit decay-causing bacteria to their child. It is important that mothers and primary care givers maintain their own oral health. Teeth decay because the bacteria in plaque (which can build up on teeth) use the food left on teeth and gums to make acid that breaks down tooth enamel.

WAYS TO PREVENT TOOTH DECAY

- Limit frequent snacking, especially on foods high in sugar.
- Brush and floss daily.
- Use fluoride toothpaste.
- Ensure that children drink fluoridated water or receive fluoride supplements.

PACIFIERS AND THUMB-SUCKING

Some children suck on pacifiers or their thumbs to help them relax. If the child needs a pacifier, be sure it is an "orthodontic" shaped pacifier that will help maintain proper growth and development of the upper jaw. Old-fashioned, round pacifiers or the child's thumb or fingers can place pressure on the growing jaw and teeth and cause the teeth to be permanently out of position. This can result in an "open bite" where the front upper and lower teeth do not touch. Correcting an open bite requires orthodontic treatment.



BABY BOTTLE TOOTH DECAY

This is a severe form of decay of the primary teeth of infants and toddlers. Sometimes, infants or young children who are allowed to suck excessively on a nursing bottle or sweetened pacifier develop a condition called "Baby Bottle Tooth Decay" or "Nursing Bottle Mouth."

Baby Bottle Tooth Decay is painful and can destroy the teeth of young children. The teeth most likely to be damaged are the upper front teeth, the ones that make a difference when a child smiles. The damage can begin shortly after the teeth have erupted.

CHILDREN CAN GET BABY BOTTLE TOOTH DECAY BY:

- Prolonged use of a bottle containing anything but **water**, such as cow's milk, formula, fruit juice, sweetened water, jello water or soda pop. This is true especially at bed or nap time, or during the day if the child uses the bottle as a pacifier, is walking around with a bottle or is sitting playing with a bottle.
- Use of a sweetened pacifier. Pacifiers should not be dipped in any kind of sweetened syrup or liquid.

BABY BOTTLE TOOTH DECAY CAN CAUSE:

- Pain, toothache
- Cavities, abscessed teeth
- Loss of teeth
- Crooked permanent teeth
- Ear and speech problems
- Possible emotional problems

Children with Baby Bottle Tooth Decay may require special hospital care to have their teeth treated.

PREVENTION

HOW TO PREVENT BABY BOTTLE TOOTH DECAY

- Never allow children to fall asleep with a bottle that contains anything but water, e.g., milk, formula, fruit juice or any sweet liquid.
- Do not let children walk around or sit with a bottle during the day. If a child needs to suck, offer a pacifier, not a bottle.
- Bottles should be used only to feed infants formula or water. Children old enough to drink juice should drink it from a cup.
- Trade the bottle for a cup by 1 year of age. Begin teaching infants to drink from a cup at age 6 - 9 months. It may be messy, but it is worth the effort. Praise children and make it a sharing time. Children love learning a new skill. By age 12 months, children will prefer drinking from a cup.



HOW TO BREAK THE HABIT

Children should be encouraged to drink from a cup and should be weaned from a bottle by 1 year of age. If children have become attached to the bottle, it may be a difficult habit to break. Children may cry or fight giving up the bottle at bed or nap time, but this will usually only last a short time.

SUGGESTIONS TO DISCUSS WITH PARENTS:

- Dilute the liquid you usually put in the nap time bottle until there is only water.
- Use a clean pacifier. Do not dip the pacifier in honey, syrup, or anything sweet.
- You may involve an older child in deciding when to stop using the bottle.

Better yet, put children to bed without a bottle. Here are some substitutes:

- Give a security blanket or a teddy bear.
- Sing or play music.
- Hold or rock the child.
- Give a back rub.
- Use a musical mobile.
- Read or tell a story.

CHILD CARE PROVIDERS CAN HELP PREVENT BABY BOTTLE TOOTH DECAY





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Chapter 9 Preventing Injuries

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Play Happy, Play Safely

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Be Prepared for Injuries

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- Child Passenger Safety
- Protect Children Such Items as Discarded Syringes, Needles and Condoms



**ARKANSAS DEPARTMENT OF
HUMAN SERVICES**



Division of Child Care and Early Childhood Education

Chapter 9 Preventing Injuries

Did you know that the number one killer of children is unintentional injury? Most of these deaths and injuries were not “accidents.” The word “accident” means a random event beyond anyone’s control and due entirely to chance. Rather, they are usually events or incidents that can be prevented. You can prevent most injuries that occur with children by:

- Checking the home, child care center and play settings for hazards and risks (unsafe areas).
- Watching and supervising children carefully.
- Understanding some prevention needs change as the child grows and develops new skills while other injury prevention needs are common at each stage of development.
- Using child safety seats, seat belts and bicycle helmets consistently and appropriately.
- Talking to children about safety and demonstrating safety behaviors (e.g., wearing your own safety belt, bike helmet, etc.).
- Reading the labels that accompany a product and checking to see if age appropriate.
- Showing and teaching children the proper and safe use of products.



INDOOR SAFETY CHECKLIST

GENERAL HOUSEHOLD

- Put secure railings and nonslip surfaces on all balconies, porches and decks. Gates with childproof latches or locks can also keep a child in a safe and supervised place. Gates should be kept closed except when in use by an adult.
- Install bars or other restraints on upper floor windows to keep children from falling.
- Install smoke detectors and test batteries monthly. Replace batteries every six months – even if they are still working. (Some newer smoke detector batteries are longer-lasting. Follow the instructions that came with your smoke detector.) Place smoke detectors on each floor of the child care center and outside each sleeping area.
- Have a fire escape plan and practice fire drills at least once a month. Schedule drills during different times of the day, e.g., nap time, play time, etc.
- Keep matches and lighters out of children’s reach.



Chapter 9 Preventing Injuries

- Cover electrical outlets with safety plugs that cover the outlet automatically when a plug is removed.
- Unplug electric appliances when not in use and store them so they cannot fall in water and cause an electric shock.
- Mark glass doors and low windows for visibility (with decals or tape) and ensure that they are made of safety glass or protected from impact.
- Install fireplaces, wood stoves and heaters according to codes. When in use, they should be inaccessible to children.
- Keep poisonous plants out of children's reach.
- Use only oral prescriptions with Child Resistant Closure (CRC) for protection of children; however, remember that these types of closures do not entirely prevent access by children. Keep prescriptions and over-the-counter medicines out of children's reach.

KITCHENS, BATHROOM, LAUNDRY, DIAPERING AREAS

- Store all medicines and cleaners in their original containers out of children's reach and/or locked up.
- Store cleaning products, medicines and food separately from one another.
- Keep bleach solution and diapering supplies out of children's reach and ensure that bleach is kept locked up.
- Be sure electrical outlets in bathrooms or by sinks in the kitchen have a Ground Fault Circuit Interrupter (GFCI).
- Set hot water temperature in sinks and tubs at 100-110°F for preschool and developmentally disabled children (120°F maximum for older children). Consult landlord or electrician for assistance in setting the temperature on your hot water heater.
- Supervise children carefully in the bathroom so that they do not fall into the tub or toilet (and become injured or drown).
- Keep laundry areas separate from child care areas.
- Display the Poison Control telephone number (800-222-1222) near the phone for quick use.

TOYS

- Make sure the toys are “age appropriate” before use.
- Avoid toys that are flammable.
- Check toys (before purchase or when brought in by a child) for sharp edges or small parts that may come off, be swallowed and cause choking.
- Develop a system to check toys often to make sure they are in good repair.
- Make sure toys are washable and cleaned regularly.
- Avoid balloons, which can be a choking hazard to small children.
- Discard old toys that show signs of wear that may cause safety hazards.

Government recalls of toys are common. Consult with the Consumer Product Safety Commission to learn about recalls of children’s toys. Visit www.cpsc.gov or call 1-800-638-2772.

HIGH CHAIRS

- Make sure bases are wide and do not easily tip over.
- Make sure chairs do not have sharp edges.
- Make sure chairs are equipped with washable waist strap, which should always be used to secure the child.
- Watertight, washable foam pads cover seat, or seat has an easily cleanable surface.

PLAYPENS AND WALKERS

- Make sure playpen slats do not have more than $2\frac{3}{8}$ inches of space between them or there is netting with small weave.
- Make sure playpen hinges lock tightly and have protective covers.
- Watertight, washable foam pads should cover the bottom of the playpen.
- Children should not be left in playpens for more than 30 minute intervals. Children should always be supervised.

Government recalls of these items are common. Consult with the Consumer Product Safety Commission to learn about recalls of these items. Visit www.cpsc.gov or call 1-800-638-2772.

NOTE: The National Committee for Injury Prevention and Control and the American Academy of Pediatrics recommend that parents should be counseled on the risks/dangers of baby walkers. In keeping with this recommendation, baby walkers should not be used in child care settings.

BABY CARRIERS THAT DO NOT HAVE DUAL USE AS CAR SEATS

- Make sure bases are wide for stability.
- Make sure nonskid surfaces are on the bottom.
- Carriers should have safety straps that are used every time child is in it.
- Carriers should not be placed on counters, tables or chairs unless an adult stays right next to the child.
- Carriers are not to be used as car seats.

BABY CARRIERS THAT HAVE DUAL USE AS CAR SEATS

- Carriers should have safety straps that are used every time a child is in carrier.
- Carriers are not to be placed on counters, tables or chairs unless an adult stays right next to the child.
- When used as a carrier, the detachable base for the car seat use should be removed.

BABY GATES AND EXPANDABLE ENCLOSURES

- Choose a style of a gate and enclosure other than the accordion-type. Gates with a straight top edge and rigid mesh screen are the best. The V-shaped or diamond-shaped openings in the mesh do not present a head entrapment/strangulation hazard, and they do not pinch fingers.
- Be sure the baby gate is securely anchored in the doorway or stairway where it is being used. Gates should be anchored at both the top and bottom of the stairway. When placing a gate at the top of stairs, a gate that bolts into the wall with hardware is the best choice.
- Gates that are retained by an expanding pressure bar should be installed with this bar on the side away from the child. Otherwise the pressure bar may be used as a toehold and may enable a child to climb over the gate.

SAFE SLEEP PRACTICES

BACK TO SLEEP

- Put infants on their backs to sleep at night and for naps. Do not put infants to sleep on their sides as they could roll onto their stomach.
- Infants need “tummy time” when they are awake and someone is watching them.
- A physician’s note for non-back sleeping should be required to explain why back-sleeping position is not recommended. The note should indicate how the baby should sleep and for what time frame.



CRIBS

- Distance between crib slats should not exceed $2\frac{3}{8}$ inches (less than the width of a soda can). This will prevent a baby’s body from slipping through the slats and possibly entrapping his or her head.
- Mattresses should fit snugly and be watertight. Plastic covers are not acceptable. This prevents baby from becoming trapped between the mattress and side of the crib.
- Crib sides should lock at full height. Full height covers $\frac{3}{4}$ of a child’s height to prevent a child from falling out of the crib.
- Corner posts should be no more than $\frac{1}{16}$ -inch high. This prevents a baby’s clothing from catching on the post, which is a strangulation risk.
- Make sure lock-on crib sides cannot be easily released.
- Make sure there are no cut-out designs in the headboard or footboard. This prevents entrapment.
- Properly mount crib gyms and mobiles. Be sure to remove them when baby begins to push up on hands and knees. No strings or cords should dangle into the crib.
- To reduce the risk of suffocation, remove all soft bedding such as bumper pads, pillows, quilts, comforters, sheepskins and other pillow-like soft products before placing baby to sleep.
- If using a blanket, use the “feet to foot” method. Place the baby at one end of the crib, with his feet near the foot of the bed. Tuck the blanket around the crib mattress at the foot and on the sides, allowing it to reach only as far as the baby’s chest.
- When using a portable crib or playpen, be sure to use only the mattress or pad provided by the manufacturer.

Government recalls of cribs are common. Consult with the Consumer Product Safety Commission to learn about recalls of infant sleep surfaces. Visit www.cpsc.gov or call 1-800-638-2772.



OUTDOOR SAFETY CHECKLIST

PLAYGROUND

- ☐ Children are always supervised by an adult.
- ☐ Play areas are checked regularly for hazardous objects or situations. Gaps in S-hooks should not admit a dime to avoid catching a child's clothing. File off excessive length in bolts flush with the unit pole. Spaces on equipment should be less than 3½ inches or more than 9 inches to prevent entrapment.
- ☐ Play equipment is installed and kept in good repair for safety.
- ☐ Play areas for children 6 - 23 months should provide places for children to crawl, stand and walk.
- ☐ Play equipment for 2 - 5 year olds can include activity panels, swings, tot swings, slides no taller than 4 feet and lower platforms. Platforms elevated more than 20 inches above the ground need guardrails or protective barriers.
- ☐ Play equipment for 5 - 12 year olds can include swings, tire swings, horizontal ladders, chain climbers, freestanding arch climbers and sliding poles. Platforms elevated more than 30 inches above the ground need guardrails or protective barriers.
- ☐ Play structures more than 30 inches high should be spaced at least 9 feet apart.
- ☐ Swings should not swing across footpaths.
- ☐ Equipment that collects water (such as a tire) should have drainage holes.
- ☐ Play equipment has soft ground surface underneath. Soft surfaces under climbing or play equipment should consist of material such as wood chips or pea gravel at least 1 foot thick/deep. Grass is not sufficiently soft to be used as a cushion under high equipment, nor is packed bare dirt.
- ☐ Surfacing zones should be 6 feet in all directions. For swings, the length of the surfacing zone should be twice the height of the beam from which the swing hangs.
- ☐ There are no projections on equipment onto which a child could fall or into which a child could run.

PLAYGROUND LEADER'S CHECKLIST

- ☐ Prepare written guidelines for playground operation, defining goals and procedures.
- ☐ Insist on first aid and incident training for playground leaders.
- ☐ Provide for constant supervision by establishing a written schedule.
- ☐ Instruct children and playground supervisors on how to use equipment. Playground equipment safety should be taught in the classroom.

- ☐ Conduct daily cleaning and check for broken glass and other litter.
- ☐ Do not permit children to use wet or damaged equipment.
- ☐ Do not permit too many children on the same piece of equipment at the same time; suggest that children take turns, or direct their attention toward other equipment or activities.
- ☐ Constantly observe play patterns to note possible hazards and suggest appropriate equipment be replaced.
- ☐ Make periodic checkups, and request that worn or damaged pieces of equipment be replaced.
- ☐ Prepare written incident reports with special attention to surface conditions, type and extent of injury, age and sex of child, how the incident occurred and weather conditions.

PLAYGROUND MAINTENANCE CHECKLIST

Inspections should be conducted on a frequent, regularly scheduled basis. The following are some of the danger points that should be checked on each tour:

- ☐ Visible cracks, bending, warping, rusting or breakage of any component
- ☐ Deformation of open hooks, shackles, rings, links, etc.
- ☐ Worn swing hangers and chains
- ☐ Missing, damaged or loose swing seats; heavy seats with sharp edges or corners
- ☐ Broken supports/anchors
- ☐ Footings exposed, cracked, loose in ground
- ☐ Accessible sharp edges or points
- ☐ Exposed ends of tubing that should be covered by plugs or caps
- ☐ Protruding bolt ends that do not have smooth, finished caps and covers
- ☐ Loose bolts, nuts, etc.
- ☐ Splintered, cracked or otherwise deteriorated wood
- ☐ Lack of lubrication on moving parts
- ☐ Worn bearings
- ☐ Broken or missing rails, steps, rungs, seats
- ☐ Surfacing material worn or scattered (in landing pits, etc.)
- ☐ Hard surfaces, especially under swings, slides, etc.
- ☐ Chipped or peeling paint

Chapter 9 Preventing Injuries

- ☐ Vandalism (broken glass, trash, etc.)
- ☐ Pinch or crush points (exposed mechanisms, junctures of moving components, e.g., axis of seesaw)
- ☐ Tripping hazards such as roots, rocks or other environmental obstacles
- ☐ Poor drainage areas

Prepared by the U.S. Consumer Product Safety Commission, "A HANDBOOK FOR PUBLIC PLAYGROUND SAFETY" (2008).

PLAY HAPPY, PLAY SAFELY

You can play an instrumental role in helping children learn to "Play Happy, Play Safely." You can teach children how to use each type of playground equipment by pointing out the following safe play habits to them.

The following equipment is not recommended for children younger than 5 years of age:

- Chain or cable walks
- Log rolls
- Swinging gates
- Parallel bars
- Long spiral slides over 360 degrees
- Freestanding arch climbers or with flexible components
- Seesaws
- Track rides
- Overhead rings
- Vertical sliding poles

SWINGS

Children should be taught to:

- Sit in the center of the swing; never stand or kneel.
- Hold on with both hands.
- Stop the swing before getting off.
- Walk way around the swing – not too close to the front or the back.
- Never push anyone else in the swing or allow others to push them.
- Have one person in one swing at one time.
- Avoid swinging empty swings and never twist swing chains.
- Avoid putting head and feet through exercise rings on the swing sets.

SLIDES

Children should be taught to:

- Hold on with both hands as they go up the steps of the slide, taking one step at a time; never go up the sliding surface or the frame.
- Keep at least one arm's length between children when climbing the steps.
- Slide down feet first, always sitting up, one at a time.
- Be sure no one is in front of the slide before sliding down.
- Be patient, avoid pushing or shoving; and to take turns.
- Leave the bottom of the slide immediately after they have taken a turn.
- Never use a metal slide that has been sitting in the sun.

CLIMBING APPARATUS

(geodesic domes or arches and jungle gyms)

Children should be taught to:

- Use the correct grip; use both hands.
- Be careful of climbing down, and to watch out for those climbing up.
- Avoid having too many people using the apparatus at one time.

(horizontal ladders and bar)

Children should be taught to:

- Start at the same end of the apparatus and move in the same direction.
- Stay well behind the person in front and watch out for swinging feet.
- Never use apparatus when it is wet.
- Avoid speed contests or trying to cover too large a distance in one move.
- Drop from the bars with knees slightly bent and land on both feet.

SEESAWS

Children should be taught to:

- Sit facing each other, not leaning back.
- Keep a firm hold with both hands.
- Never stand or run on the board.
- Keep feet out from underneath the board as it descends.



Chapter 9 Preventing Injuries

It is important that adults take the time to learn about playground safety for the sake of the children and to be properly motivated to protect all children from unnecessary hurt and risks during their play. Help the children you come in contact with **PLAY HAPPY** and **PLAY SAFELY**!

Prepared by the U.S. Consumer Product Safety Commission, “PLAY HAPPY, PLAY SAFELY” – Little Big Kids, For Ages 3-5.

WADING/SWIMMING POOLS

- Pools are always to be supervised by an adult trained in CPR. Swimming pools require the supervision of a certified lifeguard.
- Water in swimming pools must meet state or local standards for chlorine and other chemical levels.
- Pools, wading pools, hot tubs and spas must be surrounded by fences and self-latching gates, preferably five feet high, that are kept locked except when an adult is present. The fence should be hard to climb so chain link fences are not recommended. There should be no more than 4 inches between slats on the fence and from the bottom of the fence to the ground.
- Doors from the house that open into the pool area should be kept locked to keep children from walking out from the house to the pool area.
- Supervision of children around the pool area is very important and must occur whenever children are around the pool even if they are not swimming at the time. For example, children playing or riding tricycles around the pool may fall in.
- Touch supervision is advised for children under age 5. An adult should be within arm’s reach or able to touch the child in the water at all times.
- Remove all toys from the pool area after use so children are not tempted by them.

BICYCLES/TRICYCLES

- Approved bicycle helmets are to be used every time children ride bikes. We also recommend using helmets with tricycles and big wheels to help promote the helmet habit.
- Always insist the child wears a helmet. Make the rule, **“No Helmet; No Ride.”** Anyone can get hurt anywhere at any time.
- When you ride together, wear your own helmet. Your own good example can make a big difference in encouraging the child to wear one.



- Praise and reward each time the child wears it. The child may feel strange at first; take away some of the discomfort with words of support.
- Encourage parents to buy helmets. Making helmets common is the best way to eliminate the discomfort of being “different.”
- Bicycles should have handle grips, and children should be taught the proper rules of riding a bicycle.
- Buy the bicycle to fit the child so he/she will not be injured growing into the bicycle.
- Allow only one child per bicycle or tricycle.

If an injury occurs, keep calm! Be prepared and be ready to respond.

BE PREPARED FOR INJURIES

BEFORE AN INJURY OCCURS, PREPARE TO RESPOND BY TAKING THE FOLLOWING STEPS:

- **Post emergency telephone numbers by all your phones. Include your facility’s name, address and telephone number.**

The emergency phone number for most areas is:

911

The toll-free phone number for the Arkansas Poison Control Center is:

1-800-222-1222

- Keep a stocked first aid kit in a convenient location that is known to all staff. The kit should be out of reach of children. Assign one person to check it regularly and restock it as necessary. You should also have a first aid kit in any vehicle used for transportation or field trips. The first aid kit should include Syrup of Ipecac in case of poisonings. Never give Syrup of Ipecac without first calling the Poison Control Center.
- Keep parental consent forms on file to enable you to provide emergency treatment or transportation if necessary. Have complete emergency information on file for each child, including emergency contact phone numbers.
- Have child care center staff and family child care providers trained and up to date in first aid and CPR. In centers, at least one first aid and CPR-trained staff person should be present at all times, including during field trips.
- Develop written emergency procedures; plan ahead for emergencies. Orient all staff to the plan.
- An injured child requires immediate attention. Notify parents immediately of injuries that require the attention of medical personnel. Notify the Licensing Unit within one business day.



Chapter 9 Preventing Injuries

CHILD PASSENGER SAFETY

Motor vehicle crashes remain the leading cause of unintentional injury-related death among children ages 14 and under. Child safety seats and safety belts, when installed and used correctly, can prevent injuries and save lives. Unrestrained children are more likely to be injured, suffer severe injuries and die in motor vehicle crashes than children who are restrained.

PROTECT CHILDREN FROM SUCH OBJECTS AS DISCARDED SYRINGES, NEEDLES AND CONDOMS

Discarded syringes and needles and used condoms are increasingly showing up in parks and public areas. The risk of disease transmission from contact with discarded syringes and condoms is low, and certain precautions and commonsense procedures will reduce this low risk even further. If you have any questions, please contact the local health unit in your area.

First, there are four key points that child care providers, parents and others in charge of children need to follow:

- Teach children not to pick up or play with certain discarded objects that they may find in a park, playground or other place without first checking with an adult. Children are naturally curious but can learn through games, pictures and other consistent messages that some items are “ADULT ONLY” type of items.
 - » This can apply not only to used syringes and condoms, but also to broken glass or other sharp objects, other people’s possessions, garbage or strange animals.
 - » Children can learn to recognize “DON’T PICK UP” type of items and to call an adult to come and properly discard the object.
 - » To complement this teaching, examine any play doctor bags you may have and remove the syringes so children do not learn to think of these items as toys. These should be considered “ADULT ONLY” items.
 - » Do not frighten children about syringes and needles because children must accept them as necessary medical tools when they receive immunizations or other injections from medical personnel.
- Supervising children is also a critical safety step. Proper supervision of children against risks and hazards is a key element for safety.
- Check play areas regularly for unsafe or discarded objects, and modify the play environment as necessary. Properly cleaning up unsafe items before children are allowed to play will prevent contact with potential risks.
- Modifying the environment, such as adding fences or trimming back plants with thorns, which may harbor discarded objects, is also recommended.

USED CONDOMS

- A used condom is very unlikely to spread disease to anyone who merely touches it (particularly if it has dried), but for safety and hygienic reasons, washing with soap and water after direct contact with a used condom may be wise.
- Children should be instructed not to pick up discarded condoms, but rather to tell an adult. Telling children not to pick up used “balloons” can be a way to caution children who are too young to understand about condoms.
- Used condoms should simply be discarded in the garbage. A used condom may be picked up with a tool (tongs, shovel, etc.) or by wrapping and picking up in paper, plastic, etc.

USED SYRINGES AND NEEDLES

- If you find discarded syringes on your property, it is your responsibility as a property owner to properly dispose of them. If you find discarded syringes in a public place, such as a park or playground, we encourage you to dispose of them properly or to promptly notify the person in charge to properly dispose of them.
- Children should be instructed not to pick up discarded syringes, but to tell an adult.
- Syringes should only be handled by the plunger or barrel, not the needle.
- Gloves or tools may be used to pick up a syringe but are not necessary.
- Syringes with needles should be placed into a hard plastic, puncture-resistant container, or metal can (such as a coffee can) and capped or sealed. Place the syringes in the container with the needle pointing downward.
- Properly contained needles can then be brought into any Health Department Clinic and deposited into a special hard plastic container for disposal. **As a last resort**, the properly contained syringe and needle may be placed into the garbage. Do not use glass containers, as these may break in the garbage and place employees who work at transfer stations at risk of needle puncture injuries.
- If an adult or a child is stuck by a discarded needle or other sharp object, be assured that the risk of catching a disease is very low.
 - » Provide any appropriate first aid, such as washing the injury site with soap and water.
 - » The child’s health care provider should be contacted if any signs of local bacterial infection occur, such as redness or tenderness at the injury site, or if the child develops an elevated temperature.
 - » A bacterial infection can be easily treated. It is unlikely, however, that a virus such as hepatitis B or HIV/AIDS would be transmitted this way.
- If you see that discarded needles are a recurring problem in any area, please notify the local police department about this problem.





ARKANSAS HEALTHY CHILDREN HANDBOOK

6TH EDITION • 2012

Chapter 10 Preventing Illness in Child Care Settings

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ARKANSAS DEPARTMENT OF
HUMAN SERVICES



Division of Child Care and Early Childhood Education

Chapter 10 Preventing Illness in Child Care Settings

“**Preventing**” means stopping something before it happens. You can prevent many illnesses that can occur in child care settings through clean and safe habits. Diseases caused by germs are a major problem in child care because they are easily spread from one person to another. These diseases are called communicable or contagious diseases and include such diseases as flu or chicken pox.

GERMS

HOW GERMS LIVE

Germs are living things that are too small to be seen by the unaided eye. Examples are bacteria, viruses and fungi. They need food, water and warmth. They also like dark, wet areas. Germs live everywhere and are not harmful when they live in their proper places and numbers. However, when germs increase in number or exist where they’re not supposed to, they can cause disease. For example, there is a germ called staphylococcus (a bacterium) that normally lives on human skin and in the nose, and does not usually cause any problems. But if that germ gets from someone’s skin or nose into certain foods, it can grow in those foods. Then if the food is eaten, the poison that the germ makes gets into our stomachs and can cause food poisoning.

HOW GERMS SPREAD

Germs and the illnesses they cause can be spread in many ways. The most common are:

- Through contact with human waste (stool, urine)
- Through contact with body fluids (drool, blood, nose or eye discharge)
- Through direct skin-to-skin contact
- By touching an object that has germs on it (for example: a toy, the telephone, someone else’s hairbrush)
- Through the air in drops of water from sneezing and coughing

Not all germs can spread by all these ways. Some germs are not spread easily but require intimate or sexual contact.

Germs enter the body in different ways. The most common ways are through the eyes, nose, mouth and broken skin. If a germ enters the body and finds a warm place to grow, then illness can occur.

HAND-WASHING PROCEDURE

ALWAYS WASH YOUR HANDS:

- After you use the bathroom or help a child to use the bathroom
- Before you handle food or cooking utensil.
- Before you eat, we also recommend washing hands after eating
- After you change a diaper
- After you handle any items that may be soiled with bodily fluids or waste, such as blood, drool, urine, stool or discharge from the eyes and nose
- After handling pets or other animals
- After coming in from outside play time

HOW TO WASH HANDS:

- 1) Turn on water to a warm temperature.
- 2) Wet hands.
- 3) Soap up with liquid soap and rub hands together for 20 seconds. Rubbing hands together loosens germs and dirt, and allows them to be washed away. If hands are very dirty, soap up and rub hands together for at least 40 seconds.
- 4) Rinse well under running water.
- 5) Dry hands with paper towels, paper napkins or hot-air blow-dryer. Do not use a common cloth towel because it can spread germs.
- 6) Turn off water with the used paper towel(s) before throwing towel(s) in the wastebasket.
- 7) Use hand lotion if desired.
- 8) Clean fingernails daily or when hands have become very dirty.

DIAPER-CHANGING PROCEDURE

WHEN CHANGING DIAPERS:

- 1) Use a cover on the changing table that can be thrown away after each child's use. Cheap coverings to use are computer paper, wax paper, clean paper bags, butcher paper.
- 2) Gather all items needed for diapering and place near the changing table before beginning to change the diaper. Never leave a child unattended on the changing table.

- 3) Empty stool into the toilet but do not scrape or rinse the diaper out.
 - A. Place disposable diapers in a covered, plastic-lined container.
 - B. Place cloth diapers that belong to the child in a plastic bag. Seal and label it with the child's name. Send it home with the child.
 - C. Place cloth diapers from a diaper service in a diaper pail that has been provided for that purpose. Keep diaper pail covered and out of reach of small children.
- 4) Wash and disinfect the changing table after every change of diapers. To disinfect means **to clean with a bleach solution**. This is done by spraying the surface with a bleach solution (made of $\frac{1}{2}$ cup of liquid chlorine bleach mixed with 1 gallon of water), then wiping dry with a paper towel. Keep the solution in a spray bottle for easy use and make it daily, because the bleach weakens over a day's time. Keep this solution and the bleach out of children's reach.
- 5) Wash hands after every diaper change.

NOTE: The sink you use for hand washing, after going to the toilet and after changing diapers, must not be the same sink used for preparing food. A sink and covered, plastic-lined waste containers must be located close to the toilet and diapering area. Diaper-changing and toilet surfaces must be washable and kept clean. Disposable soiled items must be thrown away promptly in a safe and secure place.

SANITIZING AND DISINFECTING

Sanitize food contact surfaces (dishes, utensils, cutting boards and high-chair trays), toys that children may place in their mouths and pacifiers. Let fresh solution stand for two minutes or air-dry.

Disinfect nonporous surfaces such as diaper-change tables, countertops, door and cabinet handles and toilets. (Apply as a spray or poured fresh solution, not by dipping into a container with a cloth that has been in contact with a contaminated surface.)

Information from: Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, 3rd edition (August 2011). Elk Grove Village, IL: American Academy of Pediatrics; Washington, DC: American Public Health Association. Also available at: www.nrckids.org.



SANITIZING/DISINFECTING WITH A BLEACH SOLUTION

Disinfectants are chemicals that reduce the number of germs. Household bleach is an excellent disinfectant.

- **For nonfood surfaces:** Mix $\frac{1}{2}$ to $\frac{3}{4}$ cup of bleach in 1 gallon of water. Saturate area with the solution applied as a spray or poured fresh solution (contaminated material plus cleansing agent or bleach); leave the bleach solution on the surface(s) for a few minutes, then thoroughly rinse with clean water, and dry with a clean cloth. (Do not use a cloth that has been in contact previously with a contaminated surface for cleaning or drying.) Tap water can be used as the rinse if the water source is from a municipal water system.
- **If the area is saturated with blood or blood products, then the solution should be $1\frac{1}{2}$ cups of bleach per gallon of water.**
- **For mouthed toys or eating utensils:** Sanitize by boiling or using a dishwasher, or soak items for 2 minutes in a bleach solution and air dry. Bleach solution: $\frac{1}{2}$ cup bleach to 1 gallon of water. Then rinse items thoroughly with clean water and dry. (Bleach will corrode metal.)
- Prepare the bleach solution daily because it loses its ability to kill germs over time. Any liquid chlorine bleach mixed with cool water will do. All cleaning solutions are poisonous and must be kept out of children's reach or locked up. Keep labels on all cleaning products and solutions. Read directions before use. Cleaning products should be stored away from any food. Do not mix cleaners such as bleach and ammonia. Doing so will release harmful fumes.

Surfaces and objects that have obvious dirt on them should first be cleaned with soap and water. Then apply bleach and water solution to soiled objects and surfaces by spraying from a spray bottle or by dipping the object in the solution.

Sanitize/disinfect toys daily or when obviously dirty by using one of the following methods:

- Wash with soap and water to remove obvious dirt and, if possible, dip in chlorine bleach and water solution; rinse items thoroughly with clean water and dry with a clean cloth, allow toys to air-dry a short time before returning them to children
- Running toys through full wash and dry cycles of dishwasher
- Washing cloth toys in the washing machine with detergent and water and air- or machine-drying them

LAUNDERING AND CLEANING

HANDLING CLOTHING AND BEDDING

As mentioned earlier, some germs can be passed from child to object to another child. Anything that comes in close contact with the child can carry disease. To prevent this, certain items must be used by only one child or be laundered before being used by another child. Assign blankets, sheets, cots, cribs and mattresses to one child.

Each child's bedding (sheets, pillows and blankets) should be stored individually so the bedding does not come in contact with another child's.

Plastic bags (always kept out of children's reach), blanket bags, separate drawers, shelves or cubbyholes are all acceptable ways to separate each child's belongings.

If clothing, towels, bedding, diapers, etc., become soiled, store them safely out of reach until they are laundered (or put in the garbage if they are to be thrown away). Dirty cloth diapers and clothing should be placed in a plastic bag and sent home with the child at the end of the day.

LAUNDRY INSTRUCTIONS

The most important way to reduce germs in soiled clothing, towels, etc., is with soap and water. Adding bleach will further reduce the number of germs.

Clothing or other material soiled with bodily fluids should be washed in a washing machine separately from other items. Presoaking may be necessary for heavily soiled clothing.

Otherwise, wash and dry as usual. If the material will not be damaged by bleach, add $\frac{1}{2}$ cup of household bleach to the wash cycle. If the material is not colorfast, add $\frac{1}{2}$ cup non-chlorinated bleach to the wash cycle. (Examples of non-chlorinated bleach are Clorox II and Borateem.)

Always wash your hands after handling soiled laundry.

CLEANING SOILED FLOORS

- If a hard-surfaced floor is soiled (blood, vomit, stool, etc.), wear gloves and blot up as much as possible. Then mop or wipe the area with a germicidal detergent. Check to make sure it is safe for the floor. For cleaning, you may use (and reuse) utility or dish-washing type gloves.
- Mop heads, buckets, dustpans should be soaked in the disinfectant after use and then rinsed thoroughly or washed in hot water in a washing machine.



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- If a rug is soiled, use one of these recommendations:
 - » Use a sanitary absorbent powder, let dry and vacuum. These powders can be obtained at janitorial supply houses. They soak up spills and sanitize the floor covering.
 - » Wear gloves and blot up as much of the spill as you can. Then use a germicidal rug shampoo, using a brush to clean the rug well. Let dry, then vacuum. Soak the brush in a disinfectant and then rinse it off.

PREVENTION IS CRITICAL

The best method of preventing the spread of all types of infections is good hygiene to help stop the spread of germs. Two strategies are very important and cannot be overemphasized.

- Staff and children should wash their hands properly and frequently, using running water and liquid soap and disposing of towels after one use.
- Promptly clean soiled surfaces with a bleach solution prepared daily (1/2 cup of bleach per gallon of water).

STAFF SHOULD WASH THEIR HANDS:

- After performing any activity that involves handling bodily fluids
- After using the bathroom or helping a child use the bathroom
- After changing a diaper
- Before any activity that involves handling food or cooking utensils
- Before eating

GUIDELINES FOR EXCLUDING FROM CHILD CARE

Children and staff with symptoms of communicable disease can spread the disease to others. Children and staff should be excluded from child care until a doctor's clearance is received. The following guidelines are to help you determine when it would be better not to have the child or staff person present:

- **Diarrhea:** Increased number of watery stools in a 24-hour period; many people use a guideline of three or more watery stools in a 24-hour period as a definition of diarrhea; any child with diarrhea that contains blood or mucus should be excluded regardless of frequency
- **Vomiting:** Vomiting on two or more occasions within the past 24 hours
- **Rash:** Body rashes, not obviously associated with diapering, heat or allergic reactions to medicine, particularly if associated with fever or behavior change; many communicable

diseases have body rashes, such as chicken pox, measles, rubella (German measles), impetigo and some streptococcal infections; often a nurse or doctor is needed to diagnose communicable from non-communicable disease rashes

- **Drainage from the eye:** Thick mucus and pus draining from the eye
- **Mouth sores:** Exclude if the child is drooling, unless a physician or local health department has verified that the child is noninfectious
- **Appearance/behavior:** Unusually tired, pale, lack of appetite, difficult to wake, confused, irritable and particularly if the behavior –
 - » Prevents the child from participating comfortably in program activities
 - » Results in a need for care greater than the staff can provide without compromising the health and safety of the other children
- **Sore throat:** Sore throat if associated with fever or swollen glands in the neck

Children with mild cold symptoms who do not have the symptoms described above probably do not need to be excluded from child care. Mild colds are very common in young children and excluding them once they have cold symptoms probably does little to control the spread of the cold germ. Decisions about whether or not to exclude children with mild colds will depend on how uncomfortable the child is and how well the staff can care for the child and respond to his or her symptoms.

Ear infections are not easily spread and children should not be excluded just because of an ear infection. The main concern is that the child gets medical treatment and follow-up for the infection. Once again, if the child is extremely uncomfortable and the child care staff does not have enough time to care for him or her, then the child should be sent home.

OBSERVING AND REPORTING SYMPTOMS OF ILLNESS

Your observations provide valuable information to help parents and health care providers know how to best treat a child. The following are guidelines for observing, reporting and responding to symptoms of illness.

Report your observations rather than drawing conclusions or making a diagnosis. For example:

“Mary’s finger is swollen and bruised looking.” (observation)

NOT

“Mary’s finger is broken.” (diagnosis)

Statements that are observations provide more information and are more helpful to the parent or health care provider than the statements that come to a conclusion or make a diagnosis.

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- Give measurable facts rather than vague information. For example, a measurable statement would be, “*Johnny has a temperature of 103°F,*” rather than “*Johnny is hot.*”
- Get a second opinion when evaluating symptoms of illness and trying to decide what action to take – ask a coworker, the child care director or the child care health consultant.
- Establish policies about how illness will be handled in the child care center. Share these policies with staff and parents. Often, it is easier to convince parents to take an ill child home or not bring him or her to the child care in the first place if rules about illness are clearly stated and shared before illness occurs.
- Write about the illness in the child’s health record. It may seem silly to write, “*Johnny stayed home for three days due to a cold,*” but recording information reveals how often a child is ill and establishes patterns for his/her illness.
- Accurate record keeping helps you give factual observations to parents and health care providers.
- Report certain communicable diseases to the Arkansas Department of Health.
- Always report an illness to parents – either immediately or at the end of the day, depending upon the seriousness.

MEDICATIONS IN THE CHILD CARE

Sometimes young children need medicine during the day when they are in child care. The following suggestions will help child care providers to be sure that children get the care they need to stay healthy. These are general guidelines; there may be some exceptions to these recommendations. Always check with the parents before administering any medications to any child in your care.

If medicine is given at child care, consider these questions:

- Some medicines are used to prevent problems; others are used to treat an illness. If a child is ill and needs medicine, should she/he be at the child care center that day?
- If the medicine is an over-the-counter drug and is being used to stop a symptom (for example, a runny nose), is it really necessary to stop the symptom? Is the symptom bothering the child or interfering with normal activities such as sleeping or eating? Discuss with parent if medicine appears to be ineffective.
- If medicines do need to be given at the child care center, staff shall give or apply medication, either prescription or non-prescription, only with prior written permission and written instructions from the parent and/or the doctor. Medications must be in the original container, stored according to the instructions, clearly labeled for a named child, and returned to the parent or destroyed when no longer needed. The center or family

home shall maintain a Medication Administration Record as to the time and amount of medication given or applied.

- The child care center must obtain written permission from the parent to give any medication while the child is at the child care center or family home.
- All medications must be stored out of the reach of children. Check the label to see if the medicine needs to be refrigerated, and, if so, be sure that medicine stored in the refrigerator is out of the reach of children. Many providers use some kind of lockable container, such as a fishing tackle box with a small lock, to store medicines in refrigerators that are accessible to children.

The following general procedures should be followed when giving any medication to children:

- 1) Wash hands before preparing medications.
- 2) Prepare the medication on a clean surface that is away from toileting or diaper-changing areas.
- 3) Explain the medication-giving procedure to the child. Never call medication “candy.” You can explain that the medication tastes like bubble gum or candy, but never say that it is bubble gum or candy.
- 4) Always give plenty of praise to children after they take their medication.
- 5) Wash hands after giving medications.
- 6) Stop giving a medication if side effects are observed. Inform parents.

VARIOUS TYPES OF MEDICATION

ORAL MEDICINES (those that are taken by mouth)

- For liquid medicines, use spoons, syringes, droppers or medication cups that have measurements on them so that the correct dosage can be given. Regular table silverware spoons do not provide an accurate measurement for liquid medicine.
- Be sure that the equipment being used is clean.
- For liquid medicines, pour the medicine into the spoon or cup and hold it at eye level to check the dose. Have the child sit or be held in an upright position to help with swallowing. Do not put medicine into baby bottles. Medication can be mixed with a very small amount of a soft food, such as applesauce, only if the child has difficulty swallowing it.



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EYEDROPS

- 1) Position or hold the child in an upright position.
- 2) Pull the lower eyelid out to create a tiny cup.
- 3) Without letting the medicine dropper tip touch the lower lid, drop the appropriate number of drops into the lower lid area.
- 4) Keep the child in the upright position for several minutes.
- 5) Keep the child from rubbing eye.

EAR MEDICATIONS

- 1) Position the child with the ear that needs medication up.
- 2) Straighten the ear lobe by gently pulling it back.
- 3) Drop correct number of drops in ear.
- 4) Maintain the child's position for several minutes.

TOPICAL MEDICATIONS (ointments and creams applied to the skin)

- Apply the medication according to instructions.

INHALERS (nebulizer, updrafts, metered-dose inhalers with aerochamber)

Nebulizers (sometimes called “updrafts”) and metered-dose inhalers are different ways to give medications that must be inhaled or breathed in. When given as directed, nebulizers and metered-dose inhalers are equally effective. Misuse may result in the child not receiving the full amount of the medicine.

- Metered-dose inhalers are small handheld canisters that deliver inhaled medicine quickly to the lungs. It must be used with a spacer and mask in a young child:
 - 1) Shake the inhaler well.
 - 2) Attach the inhaler to the back of the spacer and mask.
 - 3) Place mask over the child's nose and mouth.
 - 4) Push down on the inhaler to deliver the medicine to the spacer.
 - 5) Allow the child to breathe the medicine in and out, at least six times.
 - 6) Repeat puffs as many times as instructed.

- A nebulizer (“updraft”) is an electric machine that delivers the medication to the lungs in a mist.
 - 1) Attach the medicine cup, T-piece and mask together.
 - 2) Pour prescribed medicine into the cup and tighten the lid.
 - 3) Attach ends of the tubing to the medicine cup and the nebulizer.
 - 4) Place the mask on the child and strap over the head; adjust for comfort and fit.

NOTE: A strapped-on mask is the best way to fully deliver medication. Holding a mask or mouthpiece near the child’s mouth and nose will result in most of the medication not being breathed in.
 - 5) Turn on the nebulizer and continue treatment until all medication is gone. This can take 5 to 10 minutes.



DECIDING WHAT ACTION TO TAKE FOR SYMPTOMS OF ILLNESS

DECREASED VISION AND CROSSED EYES	
Symptoms	Actions Needed if YES
Is this a sudden blindness (in part or complete)?	Call parents; parents need to call health care provider immediately
Are eyes crossed in a child who is older than six months?	Discuss with parents; needs vision screening within one to two months
Do you think that vision in one or both eyes is less than normal?	Discuss with parents; needs vision screening within one to two months

- Children who have problems seeing may squint or may not see objects when they are pointed out. Contrary to popular belief, headaches are rarely a sign of poor vision in children.
- Strabismus (lazy eye) is a condition where the eyes do not work equally. This can lead to blindness in the eyes unless it is treated. Children who have strabismus often look as if they have a wandering eye.

EYES BURNING, ITCHING and/or DISCHARGE	
Symptoms	Action Needed if YES:
Decreased vision	Call parents; needs medical attention today
Some pain in eyes	(Same as above)
Pupils are different sizes (unless child normally has different size pupils)	(Same as above)
Discharge that looks like pus	Call parents; parents need to call health care provider, see “pink eye” below
Eyes that look red and irritated	(Same as above)
Itching eyes and sneezing	Discuss symptoms with parents; this may be hay fever, and if symptoms are severe, they may wish to seek medical advice
Itching eyes and runny nose	(Same as above)
Itching eyes and seasonal occurrence	(Same as above)
Inform parents of minor symptoms when they pick up child at end of the day.	

Pink eye (*conjunctivitis*) is an infection of the white part of the eye as well as pink skin under eyelids. It can be caused by either viruses or bacteria. If caused by a virus, no medicine will help – the eyes will heal by themselves. If caused by bacteria, antibiotic eyedrops will be prescribed. The child with pink eye is contagious as long as he or she has discharge unless it is bacterial pink eye, and he or she has been getting antibiotic eyedrops for 24 hours. Exclude from child care until discharge and redness are gone or child has been on antibiotic eyedrops for 24 hours and symptoms are improving. **This also applies to staff.**



EARACHES	
Symptoms	Action Needed if YES:
Is there an ear discharge?	See ear discharge
Does child have severe ear pain, fever, irritability or decreased hearing?	Call parents; child may have middle ear infection and needs medical evaluation
Discuss earache with parents at end of day when they pick up child.	

There are two kinds of ear infections:

- **Otitis media** (*middle ear infection*)
- **Otitis externa** (*outer ear infection or “swimmer’s ear”*)

Otitis media is caused when germs become trapped and grow in the middle ear because the tube (Eustachian tube) connecting the middle ear with the throat is blocked. Children with otitis media often complain of earache, have fever, are irritable, may have a cold, may have decreased hearing and may have ear discharge. Antibiotics are often needed to treat otitis media. Otitis media is not communicable, and children do not need to be excluded from child care for this condition unless they are too ill to be cared for adequately.

Some children who have had many middle ear infections have an operation where tubes are placed in their eardrums. These tubes allow the middle ear to drain so they do not get as many infections. When children have tubes in their eardrums they should not get water in their ears. Repeated middle ear infections can cause permanent hearing loss, especially if not treated.

Swimmer’s ear (**otitis externa**) is an infection of the ear canal. Children will complain of itchy ears and moving the ear lobe may cause pain. There may also be ear discharge. Eardrops are sometimes prescribed to treat this condition.

Swimmer’s ear is not particularly communicable, and children should not be excluded from child care for this problem. Children with swimmer’s ear should not use a swimming pool because the ear needs to remain dry to heal.

EAR DISCHARGE	
Symptoms	Action Needed if YES:
Is there ear wax?	No need to do anything
Is the discharge bloody or like pus?	Call parents; child needs medical evaluation
Is there fever, cold, severe ear pain, irritability, decreased hearing?	Call parents; child needs medical evaluation. May be a middle ear infection
Is there itching, red or wet ear canal, pain when ear lobe is moved?	Inform parents of symptoms when they pick up child at end of day; may be swimmer's ear. May need medical evaluation
Is discharge (particularly bloody or clear discharge) accompanied by confusion, recent head injury or projectile vomiting?	Call parent; child needs medical care immediately
Inform parents of ear discharge when they pick up child at end of day.	

- In a child who has been complaining of ear pain, white, yellow or green discharge may mean the child's eardrum has burst. The pain to the child is greatest before the eardrum bursts because of the pressure built up in the middle ear from pus. The burst eardrum is part of the healing process and will not permanently affect the child's hearing, but the child needs medical care – antibiotics will speed the healing.
- Children often like to put things in their ears such as peas or beans. This often causes ear discharge and/or pain. These items usually need to be removed by a physician or nurse.



RUNNY NOSE	
Symptoms	Action Needed if YES:
Is there a smelly discharge on one side of nose?	Inform parents immediately as there may be a foreign body in the nose; parents need to call health care provider and have the child seen that day
Is discharge a color other than white or yellow?	Inform parents when they pick up child at end of day; parents need to call health care provider
Is discharge watery, with sneezing or eye watering? Does it occur seasonally?	May be hay fever.; discuss with parents; they may want to seek medical advice
Is there fever?	See fever
Mention runny nose to parents when they pick up child at end of day.	

- A runny nose is very common in childhood.
- Children will also have runny noses during crying and sometimes after exercising.
- Some children have runny noses because they use nose drops for too long. Nose drops should never be used for longer than five days if they contain a decongestant.

NOSEBLEEDS

- Most nosebleeds are caused by picking the nose and causing tiny blood vessels in the nose to open and bleed. Nosebleeds may also be associated with colds and hay fever.
- If a nosebleed is caused by a head injury, parents should be called so they can contact their health care provider.
- Repeated nosebleeds should be evaluated by a physician.

- To stop a nosebleed, pinch the child's nostrils together for at least 4 minutes without releasing pressure. The child should be seated. Do not tilt head back. This causes the child to gag from blood dripping down the back of the throat. A cold wash cloth applied to the nose will also stop the nosebleed. After the bleeding stops, make sure the child does not blow the nose.
- Nosebleeds lasting 30 minutes or more need immediate medical attention.

SORE THROAT	
Symptoms	Action Needed if YES:
Does the child have severe trouble swallowing or breathing, or is there more drooling than usual?	Call parents; child needs medical care immediately
Is there a fever?	Call parents; child needs medical evaluation; may have scarlet fever or strep throat
Are there large and tender glands in neck?	(Same as above)
Is there headache, general discomfort?	(Same as above)
Is there a red sandpaper rash?	(Same as above)
Report sore throat symptoms to parents at end of day when they pick up child.	

- Untreated strep infections can cause rheumatic fever, arthritis, heart and kidney disease.
- No one can tell if a sore throat is caused by a streptococcus germ until a throat culture has been done.
- Strep infections are not communicable 24 hours after treatment with antibiotics. However, it is important for the child to take all the medication as prescribed.

COUGH	
Symptoms	Action Needed if YES:
Did violent cough begin suddenly without signs of a cold, and is there difficulty breathing?	Call parents; child may have breathed in an object; needs medical care immediately
Is breathing fast or difficult?	Call parents; child needs medical evaluation
Does the child suck in ribs and not seem to get enough air?	(Same as above)
Does the child have fever?	(Same as above)

- Coughing has many causes and can accompany the following illnesses: colds, flu, pneumonia and whooping cough. Sometimes a cough may be a sign that a child has inhaled a foreign object such as a peanut.
- Persistent and continuous coughs that last more than two weeks and do not seem to be getting better may mean there is a chronic illness or problem, and the child needs to be medically evaluated.

SKIN RASHES	
Symptoms	Action Needed if YES:
Is there fever?	Call parents; exclude child from child care until parents and their physician can tell you what caused the rash*
Is there itching?	See: Ringworm, Lice or Scabies, exclude child from child care until treatment is started
*For rashes without raised bumps, see: Measles, Rubella or Scarlet Fever. For rashes with raised bumps, see Chicken Pox. Also see: Impetigo, Diaper Rashes, Baby Rashes, Cradle Cap.	
Discuss rash with parents when they pick up child at end of day.	

Children often have skin rashes with no other symptoms. Some of the rashes may be caused by allergic reactions, heat or viruses. Often mild rashes disappear as fast as they come.

DIAPER RASH	
Are the following present: • Blisters? • Small red patches beyond diaper area?	Discuss with parents at the end of the day when they pick up child. They should consult physician as diaper rash may be caused by staphylococcus germs or yeast, and may need treatment.

Steps to treat simple diaper rash:

- Keep diaper dry and change as often as possible.
- Remove rubber pants.
- Leave diaper off.
- When washing area, use plain water and soap only. Avoid commercial diaper wipes since they contain alcohol, which is painful to raw skin.

BABY RASHES

There are two very common kinds of baby rashes: one is on the face (milia) and the other is on any part of the body (heat rash). Small white bumps over the forehead, nose and cheeks in an infant are called milia. If the bumps on the face are red, they are sometimes called infant acne. No treatment is needed; they go away eventually and are harmless. They are most commonly seen on newborns and very young infants.

Small red bumps, usually in the skin fold areas, often on the neck and upper chest, are called heat rash. This may mean that the infant is bundled too much. The rash quickly goes away once the baby is unbundled. This rash is also harmless.

CRADLE CAP (Seborrhea)

Cradle cap and dandruff are the same thing. Cradle cap happens when oil glands in the scalp become overactive. An infant who has cradle cap has thick, oily, yellow, scaling patches on the scalp. Frequently, there are very small bumps on the child's forehead and behind the ears. Although it is not attractive looking, it is not harmful to the infant.

It can be treated by using a soft scrub brush to wash the scalp once a day. Sometimes it helps to put a little oil on the scalp, let it soak in for about 15 minutes and then completely wash off the oil. If oil is left on the scalp, the cradle cap will get worse.

VOMITING

Some children vomit easily for many reasons such as illness, excitement, motion sickness or even for no obvious reason. Any vomiting child should be separated from other children. If any of the following conditions exist, parents should be contacted as the child may need to be seen by a doctor or nurse:

- Child has a fever.
- Vomiting occurs more than twice a day.
- Child also has diarrhea.
- Vomiting occurs more than once after a head injury.
- Child has stomach pains and is bloated.
- Vomit contains blood, looks black or dark green.
- Child is lethargic (sleepy, not alert and responsive).
- Child has pain when passing urine.
- Infant vomited more than 2 ounces of formula in an 8-hour period.

After a child has vomited, avoid giving solid foods. Treatment for vomiting should be determined by the parent or the physician. Contact parent or guardian early to prevent dehydration.

DEHYDRATION

A major concern for children (especially infants) who vomit repeatedly is the danger of dehydration (drying out). **Signs of dehydration include:**

- Child does not urinate or wet diaper for 6 hours
- Tongue, lips, inside of mouth are dry
- No tears when child cries
- Dry skin
- Sunken eyes, sunken soft spot on heads in infants
- Listlessness (child not moving around much or showing interest in things)

Notify parents if child has signs of dehydration. The child needs a medical exam that day.

FEVER

Fever is often the body's response to infection. Other things also cause a child's temperature to rise, including food, too many clothes, excitement and anxiety. A temperature of 98.6°F is an average normal temperature but individuals vary. Many children can have a high temperature without appearing to be sick.

Steps to Take When a Child Has a Fever

- Take a closer look at the child to see if other symptoms such as diarrhea or rash are present. If so, excluding the child from child care should be considered.
- Evaluate the child's behavior. If he/she is acting very ill and the staff is unable to care for the child, the parents should be called to take the child home.
- Remove extra clothing and offer liquids.
- Do not overdress the child or sponge with alcohol or water.
- Call parents if a fever of over 100°F (axillary) occurs in someone who is less than 6 months of age so that medical advice can be obtained that day. If someone has a fever and sore throat, ear pain, cough, rash or diarrhea, see the decision-making charts on those symptoms for further information.
- Give medicines only as prescribed by health care provider or doctor. Unless prescribed by a physician, aspirin should not be given to children under 18 because of the possible connection between aspirin and Reye's Syndrome (a serious disease that can cause death).



TAKING A TEMPERATURE

Taking Temperature by Mouth

- You may take temperatures by mouth on children 6 years or older.
- Place bulb end of oral thermometer (slim, long bulb) under tongue.
- Tell child to close mouth by bringing lips together, not teeth; caution child not to bite thermometer.
- Leave under tongue for 2 minutes. Stay with the child to keep him/her still and comforted.

Taking Temperature Axillary (by armpit)

- You may take temperatures by armpit on children/people of any age.
- Place bulb end of either oral or rectal thermometer under the arm, hold arm snug against the body.
- Armpit should be dry.
- Wait 3 - 4 minutes before removing.

Reading the thermometer (for either thermometer)

- Slowly rotate thermometer until line of mercury is seen.
- Read thermometer where line of mercury ends.
 - » Normal oral temperature 98.6°F (37.0°C)
 - » Normal armpit temperature 97.6°F (36.5°C)

Cleaning thermometers (for either type thermometer)

- After each use, wash thermometer with soap and cool water, rinse, soak for 15 minutes in 70 percent alcohol solution, rinse and dry.
- Store in a protective case.

Note: The AAP no longer recommends use of mercury-containing glass thermometers. For digital colored strips or other types of temperature measuring devices, follow manufacturer's directions for use and care. To prevent spread of disease, use a new digital probe cover for each child and wipe off probe with alcohol between children.

USING HAND SANITIZERS

No chemical substitute (sanitizer solution) is as effective as running water. Hand sanitizers do not substitute for or serve as a replacement for hand washing in running water and soap.

However, if away from running water and soap (field trips, playground, etc.), the use of an alcohol-based (60 to 95 percent alcohol) hand sanitizer is an alternative to traditional hand washing with soap and water by children over 24 months of age and adults on hands that are not visibly soiled. A single pump of an alcohol-based sanitizer should be dispensed. Hands should be rubbed together, distributing sanitizer to all hand and finger surfaces, and hands should be permitted to air-dry.

Hand sanitizers should be used for “transitions” only and are not a substitute for running water and soap. Hands should be washed as soon as running water and soap are accessible in the recommended manner.

Premoistened cleaning towelettes do not effectively clean hands and should not be used as a substitute for washing hands with soap and running water.

For visibly dirty hands, a water-saturated towel (when running water is not available) should be used to remove as much dirt as possible before using a hand sanitizer.

Child care programs should follow the manufacturer’s instructions for use – check instructions to determine how long the hand sanitizer needs to remain on the skin surface to be effective.

Supervision of children is required to monitor effective use and to avoid potential ingestion or inadvertent contact of hand sanitizer with eyes and mucous membranes. The children must be monitored when using a sanitizer to ensure the product is being used appropriately.

Some hand sanitizing products contain “nonalcohol” and “natural” ingredients. It is not recommended that this type product be used.

Reference: AR Child Care Licensing Unit and Information from: Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Early Care and Education Programs, 3rd edition (August 2011). Elk Grove Village, IL: American Academy of Pediatrics; Washington, DC: American Public Health Association. Also available at: <http://www.nrckids.org>.



ARKANSAS HEALTHY CHILDREN HANDBOOK

6TH EDITION • 2012

Chapter 11 Preventing Communicable Diseases

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Quick Guide to Communicable Diseases Control



**ARKANSAS DEPARTMENT OF
HUMAN SERVICES**



Division of Child Care and Early Childhood Education



Chapter 11 Preventing Communicable Diseases

This section of the manual covers childhood diseases and ways to prevent or control their spread to other children or staff members in the child care center. Control of these communicable diseases is important for several reasons: An increasing number of children attend child care, most diseases spread more easily in areas with a number of people and children are more susceptible than adults to many diseases.

For each disease, the manual will describe the disease, how it spreads, its symptoms, its incubation period (the time between development of the disease and the appearance of the first symptoms), its communicable period (the period in which it can be passed to others) and suggestions for preventing or controlling its spread.

UNIVERSAL PRECAUTIONS

Universal Precautions are to be used when handling any bodily secretions (urine, nasal/oral secretion, stool, or blood).

- Gloves are to be worn when touching blood and bodily fluids, mucous membranes or non-intact skin.
- Gloves are to be changed after contact with each child.
- Masks and protective eye wear should be worn during procedures that are likely to generate droplets of blood or other bodily fluids to prevent exposure of mucous membranes of mouth, nose and eyes.
- Gowns should be worn during procedures that are likely to generate splashes of blood or bodily fluid.
- Precautions should be taken to prevent puncture injuries.
- All skin surfaces exposed to blood or other bodily fluids should be washed immediately and thoroughly.
- Equipment for mouth-to-mouth emergency resuscitation should be readily available.

GOOD HAND WASHING PREVENTS THE SPREAD OF INFECTIONS!

There are four basic reservoirs for infections and diseases in the child care center:

- 1) **Intestinal Tract**
- 2) **Respiratory System**
- 3) **Skin**
- 4) **Bodily Fluids (drool, blood, nose or eye discharge)**

DISEASES SPREAD THROUGH THE INTESTINAL TRACT

Child care centers that accept diapered children are at the greatest risk for the spread of diseases such as infectious diarrhea. Diseases that spread through contact with stool are among the most common in child care centers.

These diseases are spread in several ways. Young children who are diapered usually do not wash their hands and are in frequent contact with each other. Child care providers also spread the germs when they do not wash their hands thoroughly after changing diapers or after helping a child in the bathroom.

Because intestinal tract illnesses are so easily spread, **good hand washing** is especially important. Children and staff members should be taught to consider all stools to be infectious.

Thorough HAND WASHING alone may reduce the incidence of diarrhea in child care centers by as much as 50 percent.

Some simple rules to prevent the spread of all intestinal tract diseases are:

- **Encourage frequent and thorough hand washing for staff and children.**
- **Consider using gloves** when changing diapers.
- **Do not allow staff** members who prepare the food to change diapers.
- **Separate children** into three groups if possible: infants, diapered children and toilet-trained children. Try to have each staff member work with only one group of children.
- **Disinfect** diaper-change areas after every diaper change.
- **Change diapers** only in diapering area.
- **Separate** diapering area from food storage, preparation and eating area.
- **Wash hands** after diapering, helping a child in the bathroom and before preparing or eating food.
- **Wash the child's hands** after he or she goes to the bathroom.
- **Clean and disinfect** diapering areas, potty chairs, toilets and toys daily or when soiled.



Regularly scheduled environmental cleaning, e.g., vacuuming, sweeping, dusting and washing, is essential to the prevention of infectious agents. Standard household cleaning materials are adequate for most environmental surfaces; however **ALWAYS** follow manufacturing instructions **to prevent potential toxicity** from the cleaners.

Contaminated nonfood surfaces: Mix $\frac{1}{2}$ to $\frac{3}{4}$ cup bleach in 1 gallon water. Saturate area with the solution (contaminated material plus cleansing agent or bleach); leave the bleach solution on the surface(s) for few minutes, then thoroughly rinse with clean water and dry with a clean cloth. Tap water can be used as the rinse if the water source is from a municipal water system.

If the area is saturated with blood or blood products, then the solution should be $1\frac{1}{2}$ cups of bleach per gallon of water.

For mouthed toys or eating utensils: Boil either using a dishwasher or soak items for 2 minutes in a bleach solution of $\frac{1}{2}$ cup bleach to 1 gallon of water. Then, **rinse items thoroughly** with clean water and air-dry. **Bleach will corrode metal.**

Infants should not be given shared, non-washable soft toys that may be contaminated with infectious secretions.

Prepare new solution daily because it loses its ability to kill germs over time.

- Soiled diapers should be stored in covered containers (preferably with a foot-operated lid), away from food and material used by children and staff.
- Stool from cloth diapers should be emptied in the toilet. Diapers should be placed in plastic bags, stored and sent home each day with the child.

The diaper-changing surface should be covered with a smooth, moisture resistant, cleanable cover.

DIARRHEA

What is it?

Diarrhea is characterized by an increase in the usual number of stools, and they are loose, watery and unformed. Diarrhea can be caused by many different infectious germs, including bacteria, viruses or parasites. The three most common are *Shigella*, *Giardia*, and *Rotavirus*. Since child care providers will not know the specific cause of the diarrhea, you should treat all diarrheas as if they resulted from a contagious organism.

How does it spread?

It is spread as the result of direct contact with infected stool or objects (e.g., toys, eating utensils, etc.) contaminated with infected stool. Infectious germs from the stool can be spread when contaminated hands, food or objects are placed in the mouth. When people do not wash their hands well after using the bathroom, changing diapers or helping a child go to the bathroom, the germs stay on their hands and can be spread to food, drink or objects, and eventually to others' mouths. These germs are then swallowed, and multiply in the intestine and cause an infection.



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What are the symptoms?

Depending on the cause of the diarrhea, symptoms can include: fever; loose, watery stools, bad-smelling stools, gas, stomach cramps, nausea, lack of appetite, possible weight loss, stools with blood or mucus and/or vomiting. This can lead to dehydration in the child. **Dehydration** is characterized by:

- Decreased urine output; child does not pee or wet diaper for six hours
- Tongue, lips, inside of mouth dry
- No tears when child cries
- Dry skin
- Child appears thirsty
- Sunken eyes; sunken soft spot on heads in infants
- Child does not move around much or show interest in things around him/her

What is the incubation period?

The length of time depends on the infectious germ or virus – usually one day to three weeks.

What is the period of communicability?

Diarrhea can spread as long as infectious germs are present in the stool.

STEPS TO TAKE FOR DIARRHEA SYMPTOMS:

- Treatment for diarrhea should be determined by the parent and a physician. Call early to prevent dehydration.
- **Separate and exclude** children and staff from child care center who have diarrhea until they are seen by their health care provider.
- Tell parents to inform the health care provider that their child attends a child care center and whether or not any other children or child care staff are ill with diarrhea. This information will influence whether the physician obtains a stool culture and notifies the health department.
- Notify the health department if the child is diagnosed with a reportable disease (e.g., *E Coli*, *Salmonella*, *Shigella*, etc.).
- Notify the health department if there is more than one child or staff person at the child care center with symptoms of diarrhea.
- You can contact the local health unit or call 501-661-2893.
- Since certain infections require follow-up stool specimens before returning, the health department will authorize the date a child or staff member can return to the child care center.
- Encourage that young infants receive the rotavirus vaccine.

Children or child care staff who have been excluded for diarrhea may return to the child care center if the following criteria are met:

- 1) The individual(s) must be diarrhea-free (no symptoms).
- 2) If the health department is involved with the investigation, they will authorize the date of return after a determination is made that the diarrhea is not a health hazard to other children and staff at the child care center.
- 3) If a health care provider was seen, you may wish to request a note from the physician.
- 4) Reeducate staff about hand washing and diapering procedures that may prevent the spread of disease.

HEPATITIS A

**Contact the local health unit for medical recommendations
or call 501-661-2893.**

What is it?

Hepatitis A is a viral infection that causes inflammation of the liver and spreads throughout the intestinal tract. Hepatitis A is very contagious and quickly spreads in groups of children, although the major victims of the outbreaks are not the children but their adult contacts (such as child care providers or parents).

How does it spread?

Hepatitis is usually spread by the stool-to-mouth method, since the hepatitis A virus is passed out of the body in stool. It can also be spread by stool-contaminated food, drink or objects such as toys. The virus is not found in urine or saliva, and lives for only a short time in blood. It spreads quickly in groups of small children who aren't toilet trained and who cannot wash their own hands.

What are the symptoms?

Young children with hepatitis A may have no symptoms or may have a mild, flu-like illness. The virus spreads silently among the children and usually becomes evident only when it infects adult contacts. Adults who have hepatitis A may feel sick for a longer period and have loss of appetite, yellowing of the skin and whites of their eyes (jaundice), dark brown urine, nausea, loss of appetite, and fever or tiredness.

What is the incubation period?

Two to six weeks (15-50 days) after a person is exposed to the virus

What is the period of communicability?

From two weeks before to ten days after the onset of the symptoms

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How can I prevent or control the spread of the disease

**Notify and consult with the local health unit in your area
or call 501-661-2893.**

- Exclude children and adults with acute hepatitis A from child care centers for at least 10 days after the onset of the illness. **Their date of return will be determined by the local health unit.**
- Notify all parents if a child or staff member is diagnosed with hepatitis A.
- There is no treatment for hepatitis A once you have the infection; however, the illness may be prevented by a protective shot of immune globulin (IG) (if given within two weeks of exposure to the virus) or hepatitis A vaccine.
- The health department will offer and administer IG or hepatitis A vaccine **if officials determine it is appropriate treatment.**
- For long-term protection, a hepatitis A vaccine is now available for children ages 1 year and up. The health department does provide hepatitis A vaccine for children 12 months through age 18 years old, or it can be obtained from a private physician if a parent chooses.
- Thorough **hand washing is the best way to prevent the spread of infectious diseases found in the intestinal tract.**
- Clean and disinfect contaminated areas, such as diapering areas, toys, potty chairs and toilets daily or when soiled. (The hepatitis A virus may survive on these areas for weeks.)

NOTE: Control of hepatitis A in a child care center does not include closing the center.

PINWORMS

What is it?

Pinworms are intestinal worms that infect primarily preschool and school-aged children (although they can infect adults as well). The worm usually enters the body as an egg through contaminated food. It hatches and develops in the intestine. A pinworm is tiny and resembles a white thread that comes through the rectum at night and lays eggs around the opening of the rectum.

How does it spread?

Pinworms can be spread when infected children scratch the rectal area. The eggs laid by the pinworm are transferred to their hands, and if their hands aren't washed properly, the eggs may be spread to food or other objects and eventually will be swallowed. Pinworms can also be spread through contact with contaminated clothing or bedding.

What are the symptoms?

Pinworms cause rectal itching (especially at night when the pinworm comes out and lays its eggs); white, thread-like worms in stools and sleeplessness caused by the itching.

What is the incubation period?

Four to six weeks

What is the period of communicability?

As long as the eggs are present.

How can I prevent or control the spread of the disease?

- The infected child should be excluded until treatment has begun.
- All parents and staff members should be notified so they can watch the child for symptoms of pinworms.
- Washing hands after going to the bathroom and after contact with the rectal area, and before eating and preparing foods is the best way to prevent the spread of pinworms.
- Keep fingernails short.
- Contaminated bedding and clothing should be changed daily and washed in hot water.
- To prevent the spread of pinworms, each child should have their own sheets and sleeping supplies.

DISEASES SPREAD THROUGH THE RESPIRATORY SYSTEM

Another group of diseases common in child care groups is respiratory infections. These diseases are spread through droplets from nose, eye or throat secretions. Respiratory tract illnesses range from the common cold to more serious illnesses such as whooping cough or bacterial meningitis.

Respiratory diseases can spread through the air when a person coughs, sneezes, speaks or blows his or her nose. They can also be spread by objects contaminated with saliva or nasal secretions. In fact, an infected person often spreads the disease before coming down with symptoms.

The spread of many of these diseases can be avoided by thorough hand washing after coming in contact with secretions and potentially contaminated objects. Proper disposal of soiled tissues is also important.

Some simple rules to stop the spread of all respiratory system diseases are:

- **Hand washing and cleanliness are the best ways to prevent the spread of these diseases.**

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- **Wash hands thoroughly after contact with nose, throat and eye secretions**, and before preparing and eating food.
- **Do not** allow food to be shared.
- **Wash and disinfect** mouthed toys daily.
- **Use disposable** towels and tissues.
- **Dispose** of tissues in a covered container.

THE COMMON COLD

What is it?

A “cold” is the most common viral illness in children. There are more than 100 viruses that cause colds.

How does it spread?

Droplets from the nose, eye or throat, and direct contact with these infected secretions. When an infected person talks, coughs, sneezes or blows his nose, infectious droplets get into the air where they can be breathed in by another person. Droplets also can land on objects such as toys, countertops or food, and can be mouthed or touched by another person. These viruses can survive for hours on most surfaces.

Hand-to-mouth contact is the most frequent means of spreading a cold.

What are the symptoms?

Symptoms of a cold include a stuffy or runny nose, sore throat, coughing, sneezing, watery eyes, fever, fatigue and irritability.

What is the incubation period?

One to three days

What is the period of communicability?

A person can spread a cold shortly before symptoms begin and for the duration of the symptoms. The viruses are most infectious during the 24 hours before the onset and during the peak of the symptoms.

How can I prevent or control the spread of the infection?

- There is no need to exclude children and staff who have colds, unless they have significant fever.
- Children should be allowed to return to the child care center after the fever has been gone for 24 hours.

- **Good hand washing** after sneezing or coughing, or when in contact with any secretions is the first line of defense.
- **Cover mouth** with tissue when coughing and sneezing, then dispose of tissue immediately.
- **Clean and disinfect** mouthed toys daily or when soiled. Try to avoid sharing of toys when colds are present.
- **Do not give aspirin for fever control. Reye's Syndrome has been known to result from giving aspirin to children.**
- There is no treatment that can cure a "cold." Therefore, rest, fluids and medication are used to relieve the symptoms.

STREP THROAT

What is it?

"Strep throat" is a bacterial infection characterized by a red and painful throat. Strep throat occurs most frequently in children older than 3 years, during the colder months and in crowded situations. Since viruses can also cause similar symptoms, children should be seen by a physician for an accurate diagnosis and treatment.

How does it spread?

Through nose and throat secretions of the infected person. It is easily spread within the family and, therefore, easily spread in a child care setting.

What are the symptoms?

The common symptoms of strep throat are a red, painful throat; fever; swollen neck glands and a headache.

What is the incubation period?

One to three days

What is the period of communicability?

Strep throat can be spread until at least 24 hours (and in rare cases, 48 hours) after treatment has begun.

How can I prevent or control the spread of the disease?

- A child or staff member with a severe sore throat and/or other symptoms of strep throat should be sent home. They need to be seen by a physician or health care provider for a rapid strep test or a throat culture and/or treatment.
- A child with a positive strep test or culture should be **excluded** from the child care center **until 24 hours after antibiotic treatment is begun.**



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Prevent the spread of strep throat by following good hand-washing techniques.

- Thoroughly wash your hands after wiping or blowing noses, after contact with any nose, throat or eye secretions and before preparing or eating food.
- Do not allow food to be shared.
- Wash and disinfect mouthed toys at least once every day, more often if necessary.
- Teach children and staff to cough or sneeze into their shoulder or sleeve or into a tissue, which must be properly disposed of. Then wash hands thoroughly.
- Use disposable towels and tissues.

CHICKEN POX

**Contact the local health unit for medical recommendations
or call 501-661-2893.**

What is it?

Chicken pox is a very common, contagious childhood disease.

How does it spread?

Through droplets of fluid expelled from the mouth and nose during sneezing or coughing, or by direct contact with the chicken pox blisters.

What are the symptoms?

The major symptom is small blisters, usually on the chest, back, arms, legs and face. These blisters cause extreme itching. Scratching them can cause an infection and can spread the blisters. Symptoms can also include fever, a generalized achy feeling and headache one to three days before the rash/vesicles appear.

POST-IMMUNIZATION “Breakthrough”

A small percentage of chicken pox cases can occur in previously vaccinated persons. This is called a “breakthrough” rash with only a few lesions that resemble insect bites. The same rules for exclusion from child care centers apply for these cases.

What is the incubation period?

Ten to twenty-one days after exposure

What is the period of communicability?

From one to two days before the child “breaks out” until all blisters/vesicles are dried and crusted over

How can I prevent or control the spread of the infection?

- Exclude the child/staff from the child care center until all blisters/vesicles are dried.
- **Children with a compromised immune system** should be seen promptly by a physician (e.g., any child taking steroid medication, any child who has ever been treated for cancer or leukemia, or any child with AIDS).
- When a **pregnant woman** who has not had chicken pox is exposed, she should contact her physician immediately.
- **Child care providers** who have not had chicken pox should consult a physician if they are exposed to the illness.
- **Aspirin is not recommended because of its possible link with Reye's Syndrome.**
- **Chicken Pox Vaccine (Varivax)** is routinely given to children 12 months of age and older.
- The **best way to prevent the spreading of** chicken pox is through good hand-washing and cleaning procedures.
- Contact the health department for instructions about notifying parents/guardians if there is a case of chicken pox in your child care facility.

SHINGLES (HERPES ZOSTER)

Shingles infection is a reactivation of the varicella zoster virus (chicken pox).

Anyone who has had chicken pox can develop shingles if their immune system becomes weak from factors such as aging, injury, illness, etc.

Exposure to shingles will not cause shingles. However, if a person has not had the chicken pox disease or the chicken pox vaccine, that person may develop chicken pox from exposure to shingles.

MENINGITIS

**Contact the local health unit for medical recommendations
or call 501-661-2893.**

What is it?

Meningitis is an infection of the covering over the brain and the spinal cord. This disease is one of the most serious illnesses, affecting 1 child in every 400 under the age of 5. It can be caused by either viruses or bacteria, including Haemophilus influenzae type B (HIB), pneumococcus or meningococcus. Young children are at the greatest risk for acquiring meningitis.



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How does it spread?

By respiration or stool from the infected child

What are the symptoms?

Symptoms include stiff neck, fever, vomiting, tiredness, headache, irritability, poor feeding, listlessness and inability to tolerate bright light. If untreated, meningitis can lead to coma, shock and death.

There are two types of meningitis, viral (“aseptic”) and bacterial. It is important to know whether meningitis is caused by a virus or bacteria because the severity of the illness and the treatments differ.

Although they exhibit most of the same symptoms, viral meningitis is generally less severe and clears up without specific treatment.

Bacterial meningitis can be quite severe and can result in brain damage, even death. Bacterial meningitis requires antibiotic treatment.

What is the incubation period?

One to ten days

What is the period of communicability?

Meningitis can be spread until 24 hours after treatment has begun.

How can I prevent or control the spread of the infection?

- **Meningitis is a medical emergency, and the child should be seen immediately by a physician.**
- **Contact the Arkansas Department of Health for appropriate medical recommendations for children, staff and notification of parents.**
- Starting at age 2 months, Hib vaccine and pneumococcus (Prevnar or PCV13) vaccine are routinely given to infants and children to prevent certain types of bacterial meningitis.
- Require that children are up to date on their immunizations. The Hib and pneumococcus (PCV13) vaccines are recommended vaccines for children.
- For certain types of meningitis, antibiotics may be ordered by a physician for the children and staff who have close contact with the affected child.

DISEASES SPREAD BY DIRECT CONTACT (TOUCHING)

Direct contact may easily spread infections in child care settings. A child or staff member can get these diseases simply by touching the infected area of another person's body, secretions, or personal objects. Because of the inquisitive nature of young children, these infections spread easily in a child care setting.

Some simple rules to stop the spread of diseases that are spread by direct contact are:

- Thoroughly wash hands after contact with possibly infectious secretions.
- Dispose of tissues properly.
- Use soap; disposable liquid soap dispensers are preferred.
- Never use the same tissue, towel or washcloth for more than one child.
- Wash, then disinfect **toys** at least daily.
- Each child should have his/her own sleeping mat and sheets.
- Do not allow children to share personal items such as brushes, combs, blankets, hats or clothing.
- Store each child's dirty clothing separately in plastic bags. Do not launder children's clothing at the center.
- Wash and cover all sores, cuts or scrapes promptly.
- Report anything abnormal to the parents.

LICE

What are they?

Lice are small insects that live on the scalp and hair. The adult louse lays its eggs (nits) at the root of the hair where they become firmly attached. Lice may not be visible, but the eggs (nits) can be seen sticking to the hair shafts.

HOW DO THEY SPREAD?

By direct contact with the infected person or with personal objects such as hats, combs, bedding or clothing. Lice are not spread by pets, and cannot jump or fly.

What are the symptoms?

Itching is the most common symptom of head lice. Tiny pear-shaped white eggs covering the roots of the hair may be seen. Often, red bite marks or scratch marks can be seen on the child's scalp and neck. In some cases, there could be excoriations, secondary infections and lymphadenopathy present.

What is the incubation period?

Seventeen to twenty-five days

What is the period of communicability?

Until treatment has begun



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How can I prevent or control the spread of the infection?

- Infected children should be excluded until the morning after their first treatment. The risk of transmission is promptly reduced by treatment.
- Proper treatment consists of shampoos or special lotions made for the purpose of killing lice. These products are available over the counter. A second treatment, 7-10 days later, is usually recommended. Follow recommendations made by the shampoo instruction label.
- Learn to recognize nits and regularly check children's hair.
- Avoid sharing hair care items such as brushes or combs, and items such as towels, bedding, clothing and hats.
- Hang children's clothing in individual lockers or on assigned coat hooks.
- Check children for nits frequently throughout the year. Families of those children who were infected should also be checked.
- All combs and brushes should be boiled for 10 minutes or soaked for 1 hour in 2 percent Lysol solution or pediculicide shampoo.
- Vacuum floors, furniture and mattresses to get rid of lice.

SCABIES

What are they?

Scabies is a skin infection caused by a mite (a small insect of the spider family).

How does it spread?

By direct contact with an infected person. The mites can survive only a few days off the body and cannot jump or fly.

What are the symptoms?

A rash with severe itching, mostly at night, is the most common symptom of scabies. In children, the rash is most likely to appear on the head, neck, palms and soles of the feet, or between the fingers. The characteristic mite burrow consists of a short, wavy, dirty line on the skin.

What is the incubation period?

Two weeks to two months, depending on whether the infected person has had scabies before.

What is the period of communicability?

Scabies can be spread from the time a person acquires the mites until 24 hours after treatment begins.

How can I prevent or control the spread of the infection?

- Temporarily exclude the child from the center until the day after treatment begins.
- Treat infected children with medications that are effective against mites.
- It might be necessary to treat the other children and caregivers in the child's group as well as family members.
- Wash in hot water all washable items belonging to the center that came into contact with the child's skin 72 hours prior to treatment. Dry on hot cycle.
- Place difficult to wash items in tightly closed plastic bags for four days
- Vacuum any carpet or upholstered furniture.

IMPETIGO

What is it?

Impetigo is a contagious bacterial skin infection. It often occurs on the lips or nose but can occur anywhere on the body.

How does it spread?

By direct contact with the sores; sometimes it can be spread from secretions from the nose and throat.

What are the symptoms?

Common symptoms of impetigo are honey-crusted sores and a rash that looks oozy, red, round and itches. Tiny blisters form around the nose or mouth that ooze and then form scabs.

What is the incubation period?

One to ten days (usually five days)

What is the period of communicability?

Impetigo can be spread until sores are healed or the child has been on antibiotics for 24 hours.

How can I prevent or control the spread of the infection?

- Parents should contact their physician for diagnosis and treatment.
- Exclude the child until 24 hours after treatment has begun or until sores are healed.
- Wash the child's rash with soap and water. Put some type of covering over it in order to prevent spread.
- The child's hands should be washed frequently (especially after contact with the sores) with soap and water.
- Change towels, linens and clothes at least daily.
- Avoid using towels and linens used by the child.



RINGWORM

What is it?

Ringworm is a fungal infection of the skin and hair. Although ringworm is not serious and is easily treated, it is unattractive and irritating.

How does it spread?

By direct contact with infected skin or when a person comes in contact with contaminated objects. This can include animals, soil, towels, bedding, etc.

What are the symptoms?

The characteristic rash, or ringworm, is round with red or gray scaly patches. The edges may be raised, reddish and itchy. The center often looks like normal skin. On the scalp, the infection often begins as a small patch and eventually causes temporary hair loss. It may progress to patches of scaling and baldness.

What is the period of communicability?

Ringworm can be spread as long as the infected lesions are present.

How can I prevent or control the spread of the infection?

- Refer the child to the physician for a diagnosis and treatment.
- An infected child should be excluded only until treatment has begun.
- Parents and staff members should be notified if more than one person develops ringworm.
- The child care should be kept clean, dry and cool, since ringworm fungi grow in a moist, warm environment.
- Children should not share personal items such as hats, combs, towels or bedding.
- **Good personal hygiene should be practiced.**

CONJUNCTIVITIS (PINKEYE)

What is it?

Conjunctivitis is an inflammation of the conjunctiva (membrane covering the eyeball). It can be caused by either a virus or bacterial infection.

How does it spread?

Through direct contact with infected secretions of the eye, nose and throat. It can also be spread when staff members wash or dry an infected child's face and use the same towel on another child.

What are the symptoms?

The most common symptom of conjunctivitis is pink around the white parts of the eyes. The infected eyes also produce tears and discharge, pus and may itch or be swollen. Often the child's eyelids stick together in the morning because of the secretions during sleep.

What is the incubation period?

One to three days

What is the period of communicability?

Pinkeye can be spread until the active infection passes (for viral) or until 24 hours of treatment (for bacterial).

How can I prevent or control the spread of the infection?

- **Refer the child to the physician for proper diagnosis, particularly if there is yellow or heavy eye discharge.**
- If pinkeye is caused by a bacterial infection *and requires antibiotic eyedrops, exclude the child until after treatment begins.
- Use a separate cloth and towel to wash each child's face.
- **Practice good hand washing** after every contact with children's eyes.
- Dispose of contaminated tissues properly.
- Clean with soap and water, and disinfect mouthed toys or toys that come in contact with the children's eyes daily or when soiled.
- Keep the child's eyes wiped free of discharge and wash hands after contact with the child's eyes.
- Teach children to wash their hands after wiping their eyes and to try to avoid rubbing their eyes.

Note: The AAP says specifically **NOT** to exclude a child with nonpurulent conjunctivitis.

DISEASES SPREAD THROUGH BODILY FLUIDS

(BODY SECRETIONS or BLOOD)

Some very serious illnesses are spread through contact with infected bodily fluids. Fortunately, these diseases are not common in child care centers. But they are so serious that staff members should be acquainted with them and with ways to prevent them.

The viruses that cause illnesses can be spread when blood containing the virus enters the blood stream of another person. This can happen when the skin is punctured or when an infected mother transmits the infection to her newborn infant during the birth process.



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Some simple rules to help prevent the spread of diseases due to blood contact:

- Treat all blood secretions as if they were infectious.
- Use disposable gloves when handling blood or items soiled by blood or bodily fluids (urine, feces, vomitus, saliva or nasal secretions).
- Clean all blood spills promptly and then disinfect the area with a bleach solution.

CYTOMEGALOVIRUS (CMV)

What is it?

CMV is a common virus that is harmless to most people, but it is the leading cause of congenital viral infections transmitted through pregnant women to their developing fetuses. Thus, CMV is a concern mainly to the women in the child care center and to mothers in their childbearing years who have children attending the child care center.

If a pregnant woman who has never had CMV becomes infected, especially during the first trimester, the fetus may also become infected. If this happens, the fetus may suffer mental retardation, hearing loss, seizures or blindness. It is estimated that 10-80 percent of children in child care centers excrete CMV in their urine (depending on their age).

How does it spread?

CMV is present in the urine, saliva, blood, tears, stools, cervical secretions and semen of infected individuals. Transmission of CMV results from close personal contact with infected individuals, often children or sexual partners. A pregnant woman can transmit the virus to her developing fetus and can also transmit the virus to the newborn in the birth canal. Mothers can also transmit the virus in their breast milk. Transmission can also occur through the transfusion of infected blood products.

Contagion between children may occur by sharing mouthed objects or toys that have infected saliva on them, since CMV virus has been found on toys. Another source is contact with urine or stool when changing the child's diapers. This virus can be spread from one person to another if good hand-washing techniques are not utilized after changing diapers. CMV has been shown to spread in child care centers, most often from toddlers who lack control of bodily secretions.

What are the symptoms?

In most cases, CMV causes no symptoms. Occasionally, children or adults with CMV will experience mononucleosis-like symptoms such as fever, swollen glands and fatigue.

What is the incubation period?

Unknown

What is the period of communicability?

The virus may be present in the urine or saliva for an indefinite period.

How can I prevent or control the spread of the infection?

- Children known to have CMV do not need to be excluded from the child care center, since other children may also have CMV.
- Since most infected children will not be identified, saliva and urine should always be treated as potentially infectious.
- Child care providers should always practice good personal hygiene. This includes frequent hand washing, especially after changing diapers, assisting in the bathroom or coming into contact with a child's saliva or other bodily secretions.
- Kissing any child on the mouth should be minimized, especially if the child is known to have CMV.
- Routinely clean and disinfect items contaminated with saliva or urine using a strong bleach solution of $\frac{1}{2}$ to $\frac{3}{4}$ cup of bleach in 1 gallon of water. Leave the solution in contact with the surface for a few minutes, then thoroughly rinse with clean water and dry with a clean cloth.
- Do not allow sharing of personal items that may have been contaminated with blood or bodily fluids such as tooth brushes, washcloths or toys.
- There is no need to report CMV.
- Pregnant women should avoid hands-on contact with infants with congenital CMV infections.



QUICK GUIDE TO COMMUNICABLE DISEASES CONTROL

DISEASE	HOW SPREAD	INCUBATION PERIOD	SYMPTOMS OF ILLNESS	COMMUNICABLE PERIOD	MINIMUM ISOLATION PERIODS AND CONTROL MEASURES
Chicken Pox Report to the local health unit	Infected respiratory droplets or direct contact with blisters	10 to 21 days	Fever, skin eruption begins as red spots that become small blisters (vesicles) and then scab over	For 1 to 2 days before the rash until vesicles are dried and crusted	Report immediately by telephone. Exclude child until all lesions are dried and crusted, and child is afebrile. Alert the parents of immunosuppressed child(ren) of possible exposure.
Conjunctivitis (Pinkeye)	Direct contact with infected secretions	24 to 72 hours	Redness of white of eye, tearing, discharge of pus	Until symptoms have disappeared and (if bacterial infection) 24 hours after starting treatment	Exclude child until 24 hours after treatment started (if bacterial infection) and eye is comfortable, urge medical care. No exclusion of contacts.
Coryza (Common Cold)	Contact with infected droplets	24 to 72 hours	Nasal discharge, soreness of throat	One day before symptoms and usually continuing for about 5 days	Exclusion unnecessary; no exclusion of contacts
Diphtheria Report to the local health unit	Contact with infectious respiratory droplets	2 to 6 days	Fever, sore throat, often gray membrane in nose or throat	Usually up to 2 weeks	Report immediately by telephone.

Report all cases of communicable diseases to the local health unit or call 501-661-2893.

DISEASE	HOW SPREAD	INCUBATION PERIOD	SYMPTOMS OF ILLNESS	COMMUNICABLE PERIOD	MINIMUM ISOLATION PERIODS AND CONTROL MEASURES
Enterobiasis (Pinworm, Threadworm, Seatworm)	Direct contact with infected stool	Life cycle about 4 to 6 weeks	Irritation around anal region, visible in stool	As long as eggs are being laid, usually 2 weeks	Exclude until treated as documented by physician approval; no exclusion of contacts; careful hand washing is essential
Fifth Disease	Probably by contact with respiratory secretions	Estimated at 4 to 14 days	Minimal symptoms with intense red rash on cheek that appears as if child has been slapped; lace-like rash on body	Unknown	Once rash appears child is not contagious; no exclusion of contacts
Hepatitis A Report to the local health unit	Fecal-oral contact with contaminated stool	15 to 50 days, with average of 28 to 30 days	Fever, nausea, loss of appetite, abdominal discomfort and jaundice	Two weeks before until 10 days after onset of symptoms	Report immediately by telephone. Exclude for no less than 10 days after onset of symptoms. Local health unit will authorize return; careful hand washing is essential
Herpes Simplex HSV-Type I (Example: Fever Blister)	Direct contact with sores	2 to 12 days	Onset as clear vesicle, later purulent; scabs following rupture and heals in 1 to 2 weeks; commonly about lips and in mouth	For a few weeks after appearance of vesicle	Exclusion unnecessary; no exclusion of contacts; avoid contact with immunosuppressed or eczematous persons; good personal hygiene, avoid sharing toilet articles. Contact local health unit immediately if HSV Type II suspected
HSV Type II	Sexual contact.	2 to 14 days			

Report all cases of communicable diseases to the local health unit or call 501-661-2893.



DISEASE	HOW SPREAD	INCUBATION PERIOD	SYMPTOMS OF ILLNESS	COMMUNICABLE PERIOD	MINIMUM ISOLATION PERIODS AND CONTROL MEASURES
Impetigo	Direct contact with sores	1 to 10 days	Running, open sores with slight marginal redness – (rusty, honey-like drainage)	As long as lesions draining, and case hasn't been treated	Exclude until lesions brought under treatment as documented by physician. Cover wounds ; no exclusion of contacts; good personal hygiene is essential; avoid common use of toilet articles.
Influenza	Respiratory droplets	24 to 72 hours	Fever and chills, often back or leg aches, sore throat, nasal discharge and cough; prostration	From 1 to 2 days before onset of symptoms until about a week thereafter	Exclude for duration of illness; no exclusion of contacts. Annual flu vaccines can prevent most flu infections.
Measles (Rubeola) Report to the local health unit	Infected respiratory droplets	8 to 12 days From the appearance of rash to subsequent cases is usually 14 days. (Although can be as early as 7 – up to 18 days)	Begins like a cold; fever, blotchy rash, red eyes, hacking frequent cough	1 to 2 days before onset of symptoms (3-5 days before the rash) to 4 days after the appearance of the rash	Report immediately by telephone ; exclude for duration of illness and no less than 4 days after onset of rash; exclude unimmunized children from date of diagnosis of first case until 14 days after rash onset of last known case, until measles immunization received or laboratory proof of immunity is presented or until history of previous measles infection is physician verified

Report all cases of communicable diseases to the local health unit or call 501-661-2893.

DISEASE	HOW SPREAD	INCUBATION PERIOD	SYMPTOMS OF ILLNESS	COMMUNICABLE PERIOD	MINIMUM ISOLATION PERIODS AND CONTROL MEASURES
Meningitis (<i>Bacterial and Viral</i>) Report to the local health unit	Infected respiratory droplets	Varies depending on causative agent: 2 to 10 days	Sudden onset of fever; intense headache, nausea, often vomiting, stiff neck, delirium or petechial rash, shock	Variable	Report immediately by telephone; exclude for duration of illness; no exclusion of contacts; chemoprophylaxis is sometimes appropriate for family and intimate contacts; local health unit will determine if chemoprophylaxis indicated
Mumps (<i>Epidemic Parotitis</i>) Report to the local health unit	Infected respiratory droplets or direct contact	12 to 25 days (average 14-18 days)	20-40% of those infected do not appear ill or have swelling; 60-70% have swelling with pain above angle of lower jaw on one or both sides.	1 to 2 days before onset of parotoid swelling to 5 days after onset of parotid swelling	Report immediately by telephone
Pediculosis (<i>Head or body lice</i>)	Direct contact with infected person or personal objects	Eggs of lice hatch in about a week; mature in about 2-3 weeks	Itching; infestation of hair and/or clothing with insects and nits (lice eggs)	While lice remain alive and until eggs in hair and clothing have been destroyed. Direct and indirect contact with infested person and/or clothing required.	Exclude until treatment is started; no exclusion of contacts; however, they should be notified of exposure; specific treatment usually lindane or pyrethrin shampoo and nit comb

Report all cases of communicable diseases to the local health unit or call 501-661-2893.



DISEASE	HOW SPREAD	INCUBATION PERIOD	SYMPTOMS OF ILLNESS	COMMUNICABLE PERIOD	MINIMUM ISOLATION PERIODS AND CONTROL MEASURES
Pertussis (<i>Whooping Cough</i>) Report to the local health unit	Infected respiratory droplets	7 days – usually within 10 days	Irritating cough – symptoms of common cold usually followed by typical whoop in cough in 2-3 weeks	About 7 days after exposure to 3 weeks after typical cough; when treated with appropriate antibiotics, should not be infectious after 5 days after onset of therapy	Report immediately by telephone; chemoprophylaxis may be considered for family and close contacts. Local health unit will make recommendations on treatment of contacts
Poliomyelitis (<i>Infantile Paralysis</i>) Report to the local health unit	Direct contact with infected stool or respiratory droplets	3 to 6 days for nonparalytic cases and 7 to 21 days for paralytic cases	1. Nonspecific illness with low fever and sore throat. 2. Approx. 95% of cases are asymptomatic. 3. Can cause paralysis	Not accurately known. Maybe as early as 36 hours after infection; most infectious during first few days after onset of symptoms	Report immediately by telephone
Ringworm (<i>Tinea Infections</i>)	Direct contact with infected skin or contaminated objects	10 to 14 days	Scaly patches of baldness of scalp; brittle and falling hair; usually oval-shaped lesion	As long as infectious lesions are present, especially when untreated	Exclude until treatment started; no exclusion of contacts; good sanitation practices and don't share toilet articles
Rubella (<i>German Measles</i>) Report to the local health unit	Infected respiratory secretions or direct contact with infected blood, urine or stool	16 to 18 days (with range of 14 to 23 days)	Low-grade fever, slight general malaise; scattered measles-like rash; duration of approximately 3 days	From a few days before until 7 days after onset of rash	Report immediately by telephone

Report all cases of communicable diseases to the local health unit or call 501-661-2893.

DISEASE	HOW SPREAD	INCUBATION PERIOD	SYMPTOMS OF ILLNESS	COMMUNICABLE PERIOD	MINIMUM ISOLATION PERIODS AND CONTROL MEASURES
Scabies	Direct contact with infected person contaminated clothing for 3-day period	Infection caused by almost invisible mite; lesions symptomatic after 2 to 6 weeks	Severe itching; lesions around loose fleshy tissue (e.g., finger webs, elbows, crotch, etc.)	Until mites and eggs are destroyed	Exclude for 24 hours after treatment is started; no exclusion of contacts
Streptococcal Infection (Scarlet Fever, Scarletina, Strep Throat).	Infected respiratory secretions	1 to 3 days	Sore throat, fever, headache. Rough rash 12-48 hours later	Until 48 hours after treatment begun	Exclude for duration of illness; noexclusion of contacts; early medical care important and usually requires 10 days of antibiotic treatment; screening for asymptomatic cases not recommended
Tuberculosis Pulmonary Report to the local health unit	Prolonged exposure to infectious respiratory droplets	Highly variable – depends on age, lifestyle, immune status. Primary: 4 to 12 weeks. Latent: 1 to 2 years after infection – life-long risk	Weakness, cough, production of purulent sputum, loss of weight, fever; urinary tract symptoms if this system involved	Until sputum is free from tuberculosis bacteria. Generally after a few weeks of effective treatment	Exclude; physician treatment essential; may return with documented physician and local health unit approval

NOTE: Careful hand washing is the most important thing that can be done to prevent the spread of most infectious diseases.



INSTRUCTIONS FOR REPORTING COMMUNICABLE DISEASES TO THE ARKANSAS DEPARTMENT OF HEALTH

The “Rules and Regulations Pertaining to Communicable Disease Control” adopted by the Arkansas State Board of Health in 1977 pursuant to the authority conferred by Act 96 of 1913 (Arkansas statutes, 1947, Section 82-110) Section III, states “The responsibility for reporting certain communicable diseases is the duty of EVERY physician, practitioner, nurse, superintendent or manager of a dispensary, hospital, clinic, nursing or extended care home and laboratory personnel examining human specimens resulting in the diagnosis of notifiable diseases or any person in attendance on a case of any disease or conditions declared notifiable.”

The following diseases (suspected or confirmed) are to be reported immediately to the Arkansas Department of Health. They are of special importance or may indicate a bioterrorism event.

Anthrax	Botulism	Hepatitis A	Meningococcal Inf.	
Pertussis	Plague	Q Fever	SARS	Smallpox
Tularemia	Typhus	Viral Hemorrhagic Fevers	Emerging Threat Agents	

**TO REPORT DISEASES IMMEDIATELY VIA TELEPHONE,
CALL 501-661-2893 (Local/Pulaski Co. – 8 a.m.-4:30 p.m., M-F)
AFTER HOURS AND ON WEEKENDS, PLEASE CALL 1-800-554-5738**

The following diseases of public health significance are to be reported to the Arkansas Department of Health within 24 hours of diagnosis. Reports should include: 1) the reporter’s name, location and phone number; 2) the name and onset date of the disease; 3) the patient’s name, address, phone number, age, sex and race; 4) the attending physician’s name, location and phone number; 5) any pertinent clinical, laboratory, and treatment information. Report by Fax to 501-661-2428; 24-hour answering machine 800-482-8888; in person to 501-661-2893.

The following bacterial isolates must be submitted to the State Health Department Laboratory for further testing:

Aids	Leprosy (Hansen’s disease)
Blastomycosis	Listeriosis
Brucellosis	Lyme Disease
CD4+ T-Lymphocyte Count	Malaria
Campylobacteriosis	Measles (Rubeola)
Chancroid	Meningitis
Chlamydial infections	Mumps
Cholera	Poliomyelitis
Congenital Rubella Syndrome	Psittacosis
Congenital Syphilis	Rabies, animal
Creutzfeld-Jakob Disease	Rabies, human
Cryptosporidiosis	Rheumatic fever
Cyclosporiasis	Rocky Mountain Spotted Fever
Diphtheria	Rubella
Ehrlichiosis	Salmonellosis (including Typhoid)
Encephalitis, all types	Shigellosis
Enterotoxigenic E. coli	Streptococcal Disease, invasive, group A
Food poisoning, all types	Strep. Pneumoniae, Invasive, Indicate if antibiotic resistant
Giardiasis	Syphilis**
Gonorrhea	Tetanus
Haemophilus influenzae, invasive disease	Toxic Shock Syndrome
Hantavirus Pulmonary Syndrome	Toxoplasmosis
Hemolytic-Uremic Syndrome	Tuberculosis
HbsAg-positive pregnant female	Vancomycin-resistant enterococci
Hepatitis (type A, B, C or Unspecified Histoplasmosis)	Varicella (chicken pox)
HIV (Human Immunodeficiency Virus)	West Nile Virus
Influenza (viral type, if known)	Yellow Fever
Influenza deaths in persons < 18 years old	
Kawasaki Disease	
Legionellosis	

REPORTABLE OCCUPATIONAL DISEASES AND OTHER CONDITIONS

Asbestosis
Blood Lead Levels*
Byssinosis
Chemical Poisoning, All Types***
Pesticide Poisoning
Pneumoconiosis (Coal Workers)
Mesothelioma
Silicosis

REPORT ANY UNUSUAL DISEASES OR OUTBREAKS THAT MAY REQUIRE PUBLIC HEALTH ASSISTANCE

* Blood lead levels over 10 ug/dl for patients 14 years or younger and levels over 25 ug/dl for patients 15 years old and up.

** Any woman infected with AIDS, HIV or Syphilis who is pregnant must be so reported indicating the trimester of pregnancy. This applies each time the woman becomes pregnant.

*** Includes chemical agents of terrorism

Neisseria meningitidis; Salmonella sp.; Enterotoxigenic E. coli; Listeria sp.; Staph. aureus, vancomycin resistant or intermediate susceptible; outbreak-related Campylobacter sp. and Shigella sp., or on request; Haemophilus influenzae (invasive).

**TO REPORT DISEASES IN THE SECOND LIST ABOVE, PLEASE CALL THE
NONEMERGENCY DISEASE-REPORTING SYSTEM AT 1-800-482-8888 OR
FAX A DISEASE REPORT TO 1-501-661-2428**



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Chapter 12 **Recommendations Relating to Spread of Disease (Licensing and Accreditation)**

Chapter Content

Best Practice Recommendations

- Toilet Use
- Diaper Changing
- Hand Washing
- Garbage Disposal
- Water Supply
- Heating and Ventilation
- Cleaning and Sanitizing/Disinfecting
- Storage
- Sleeping Equipment

Referral to Licensing Rules and Regulations

Safety Concerns



ARKANSAS DEPARTMENT OF
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Division of Child Care and Early Childhood Education

Chapter 12 **Recommendations Relating to Spread of Disease (Licensing and Accreditation)**

Continuous and accurate attendance records should be maintained for each child, including arrival and departure times.

The current record of immunizations and/or a written program for further immunizations should be obtained for each child enrolled in a child care program.

The caregiver shall notify all parents of any communicable disease.

Child care facilities should always implement “best practice” recommendations as identified in the following nine areas:

Toilet Use

- A clean toilet and hand-washing facility should be located in the best place in each classroom to meet the developmental needs of children and must be easily accessible.
- Equipment used for toilet learning/training should be provided. This equipment should be such that it can be easily cleaned and disinfected and used only in bathroom areas.
- Equipment should be cleaned and disinfected after each use in a sink exclusively used for cleaning them.
- Keep toilet rooms clean, in good repair, well lighted, well ventilated and fully enclosed.

Diaper Changing

- Change infant's diaper as needed.
- Facility should have at least one diaper-changing table per infant or toddler group.
- Use individual washcloths, towels or disposable towelettes to cleanse infant during diapering.
- Clean diaper-changing surfaces after each use by sanitizing the surface or the sanitizable diaper-changing pad.
- Hand-washing sinks in centers should be provided within arm's reach of the caregiver to diaper changing tables and toilets.
- Caregiver must wash hands thoroughly before and after diaper-changing (even if gloves were worn).
- Wash infants/toddlers hands after diaper changing, before they return to the supervised area.



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- Have tightly covered, hands-free receptacles for diaper disposal within arms' reach to prevent environmental contamination.
- Diaper-changing areas and food preparation areas should always be physically separated.

Hand Washing

HAND HYGIENE IS THE MOST IMPORTANT WAY TO REDUCE THE SPREAD OF DISEASE.

- All caregivers and teachers should be aware of the correct hand-washing technique, and it should be taught to all children when developmentally appropriate.
- Hand hygiene should be practiced before and after:
 - » Preparing food
 - » Eating and feeding a child
 - » Giving medications
 - » Diapering
- Hand-washing areas should be accessible without barriers to each child.
- Sinks should be placed at the child's height or be equipped with a stable step platform for easy and safe access as needed.
- Sinks should be provided at a ratio of one sink to every 15 children.
- Provide hot and cold running water, at a temperature of at least 60°F and no hotter than 120°F.
- A supply of hand-cleansing, nonbacterial, unscented liquid soap should be provided at each sink.
- Clean, disposable, single-use paper towel should be made available.
- **Hand sanitizers do not substitute for or serve as a replacement for hand washing in running water and soap.** Hand sanitizers should be used for *"transitions only."*
- EPA-labeled, approved alcohol-based sanitizers are an appropriate alternative for use in children above 24 months of age under supervision when running water and soap are not immediately available. *However, hands should be washed as soon as running water and soap are accessible in the recommended manner.*

Garbage Disposal

- Garbage should be removed from rooms occupied by children on a daily basis and removed from the premises at least twice weekly or more often as regulated.

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- Containers approved by the regulatory health authority should be used. They should be kept covered with tight-fitting lids or covers when stored. Plastic garbage bag liners should be used.
- Soiled diapers should be stored inside the facility separate from other wastes.
- Each waste and diaper container should be labeled to show the intended content.
- Ensure that sewage and liquid water is properly discharged into a municipal sewage system (if available).

Water Supply

- Every facility should be supplied water from an EPA/other regulatory-authority-approved source.
- The piped running water should be sufficient and under pressure to supply for cooking, cleaning, drinking and toilets.
- Adequate water-heating facilities should be provided.
- Drinking water should be provided by sanitary drinking fountains or individual cups.
- The use of common drinking containers are prohibited.

Heating and Ventilation

- All heating and ventilation equipment must meet the requirements of the state regulatory authorities (fire department and health department).
- As much fresh air as possible should be provided in rooms occupied by children.
- A draft-free temperature of 68°F to 75°F should be maintained during winter and temperature of 74°F to 82°F should be maintained during summer.
- Rooms should be clean and dry.
- All openings to the outside, where flies and other insects are prevalent, should have effective screening.
- All heating and ventilation equipment should be inspected and cooled before each heating and cooling season.

Cleaning and Sanitizing/Disinfecting

- Facilities should follow a routine schedule of cleaning and sanitizing/disinfecting.
- Cleaning and sanitizing/disinfectant solutions should not be used in close proximity to children. Adequate ventilation to prevent children and caregivers from inhaling toxic fumes is necessary during any cleaning procedure.

Chapter 12 **Recommendations Relating to Spread of Disease (Licensing and Accreditation)**

Storage

- Separate areas for storage of every child's personal objects should be provided.
- All personal belongings, such as toothbrushes, washcloths and combs, should be stored in separate, labeled, clean containers and should be labeled with the child's name.
- Children should not be given access to storage areas.

Sleeping Equipment

- An individual cot, crib or mat and a separate cover should be provided.
- Each crib should have a waterproof mattress.
- Cots, cribs, and mats should be disinfected daily, marked by individual use and disinfected weekly or more often as needed.

SAFETY CONCERNS*

Child care centers shall comply with the Minimum Requirements of The National Fire Safety Code 101 as administered by the local fire department or by the State Fire Marshal, who has final authority.

- Child care centers should have heating systems inspected and cleaned by a qualified technician at least annually or more often if required by local/state law.
- It is further recommended that **smoke detectors** should be installed on all floors of the facility.
- Instructions in an "escape plan" (fire drills) and in "stop, drop and roll" could save many lives in case of fire or smoke.

Properly installed smoke alarms are 50 - 80 percent effective in preventing fire related death.

NOTE: The state and local fire codes may not allow the use of basements or floors above ground level by children first grade and younger, unless there is a ground level exit.

Carbon Monoxide is a deadly, colorless, odorless, poisonous gas. It is produced by the incomplete burning of various fuels. **Carbon monoxide detectors** are the only way to detect this substance. The symptoms mimic the flu: mild symptoms are typically headache, dizziness, fatigue and diarrhea. Prolonged exposure can cause confusion, shortness of breath, unconsciousness and eventually death.

- Although not required by any state or local law, except for any new home construction after January 1, 2012, and the state licensing agencies, **carbon monoxide detector(s)** should be installed in child care facilities if "the child care program uses any sources of coal, wood, charcoal, oil, kerosene, propane, natural gas or any other product that can produce carbon monoxide indoors or in an attached garage."

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Major appliances should be professionally installed and inspected. Older appliances should be checked for malfunctions and leaks. Never use a gas oven to provide heat in a facility.

**NOTE: Information for this section is from “Caring for Our Children,” 3rd Edition, 2011 and Arkansas Licensing Minimum Licensing Requirements (REV. 11/1/2011). Please refer to the appropriate Minimum Licensing Requirements manual# for questions. If additional information is needed, you may call 1-501-682-8590 or 1-800-445-3316. #DISPONIBLE EN ESPAÑOL*
<http://humanservices.arkansas.gov/dccece/Pages/ChildCareLicensing.aspx#ChildCareLicensing>



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Chapter 13 HIV/AIDS Infection Control

Chapter Content

Guidelines for Infection Control

Sample HIV Policy for Child Care Programs



**ARKANSAS DEPARTMENT OF
HUMAN SERVICES**



Division of Child Care and Early Childhood Education

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ARKANSAS HEALTHY CHILDREN HANDBOOK

Chapter 13 **HIV/AIDS Infection Control**

GUIDELINES FOR INFECTION CONTROL

HIV is the virus that causes AIDS. It stands for Human Immunodeficiency Virus. HIV attacks the immune system and makes it difficult for the body to fight off infection (immunodeficiency). AIDS is Acquired Immunodeficiency Syndrome.

HIV is spread only by three ways:

- 1) Blood-to-blood contact (where a sufficient amount of infected blood gets into the bloodstream of another person);
- 2) Sexual intercourse (where certain infected body fluids get into the body of another person); and
- 3) From a pregnant woman to the fetus or newborn or through the mother's breast milk.

Scientific studies continue to show that HIV is not transmitted in any other way, even from close contact such as that which occurs among children and staff in group programs.

Therefore, the following guidelines are suggested for infection control in child care programs regarding HIV infection:

- HIV-infected children should be admitted to group programs if their general health, neurological development and behavior are appropriate. Questions regarding admission of a child with HIV infection should be resolved on an individual basis in consultation with a health care professional who has expertise regarding HIV infection, preferably the child's own physician.
- HIV-infected children who persistently bite others or who have oozing skin lesions may pose a theoretical risk for spread of the virus, but cases of HIV transmission in these ways have not been reported.
- Blood testing children for HIV prior to entering a child care program is neither warranted nor recommended. Parents of children attending group programs do not have the right to know the HIV/AIDS status of other children or staff in the program. Arkansas law only requires that HIV-infected individuals inform potential sex partners or persons providing medical care to them of their HIV/AIDS status.
- Child care facilities should have standard practices to reduce the spread of infections of various sorts. Recommended practices include promptly cleaning soiled surfaces with disinfectant solution (mix $\frac{1}{2}$ to $\frac{3}{4}$ cup of bleach in 1 gallon of water*); using disposable towels and tissues with proper disposal; and using disposable gloves when touching mucous membranes, any open skin lesions, or blood or blood-contaminated body fluids. These are precautions that should be routine for all settings.

***Note: If the area is saturated with blood or blood products, then the solution should be $1\frac{1}{2}$ cups of bleach per gallon of water.**

SAMPLE HIV POLICY TO BE USED BY CHILD CARE PROGRAMS

While concern about HIV/AIDS is natural, studies continue to show that HIV does not spread in the absence of sexual contact or blood-to-blood contact, even in normal intimate family living situations (including child care settings).

The Arkansas Department of Health recommends the following policy:

We will not exclude children, family members or staff based only on their being infected with HIV (the virus that causes AIDS). We will attempt to protect the privacy of such individuals. Caretakers need to know if a child has other physical limitations or special needs that require accommodation, whether these are related to HIV infection or not. We strongly discourage mandatory HIV testing prior to enrollment or employment.

The following resource is recommended by a public health official at the Arkansas Department of Health:

“Infection Control in the Child Care Center and Preschool” by Leigh G. Donowitz, published by Lippincott Williams and Wilkins, and available by calling 1-800-638-0672, ISBN 9780683180411.



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Chapter 14 **First Aid in Emergencies**

Chapter Content

Emergency Help

First Aid Kit

Supplies

Your Response During Emergencies

Shock

Bites and Stings (Human-Animal-Insect-Snake)

Bleeding

Bone-Joint Injury

Bruises

Burns (Small-Large-Blistered-Chemical)

Choking on Small Objects (Airway Obstruction)

Convulsions/Seizures

Dental Injuries (Problems)

Eye Injuries

Head/Spinal Injuries

Poison Ingestion



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Chapter 14 **First Aid in Emergencies**

THIS FIRST AID INFORMATION IS TO BE USED AS A GUIDE ONLY.

Follow the advice of emergency medical personnel or a health care provider.

First aid and CPR certification is a valuable asset for work in the child care field.

Preparation is KEY – staff members should be trained at the time of hire and annually thereafter. Regular drills to practice emergency response should be scheduled.

When a child becomes ill or injured at child care, it may be necessary to obtain emergency medical care. Contact the parents immediately. It is critical that families provide updates to the child care facility whenever there are changes in emergency contact information.

The following are examples of symptoms that could mean that a child needs immediate medical attention.

- Serious injury.
- Breathing that is difficult or fast.
- Child sucks in ribs and doesn't seem to get enough air.
 - » Severe cough or wheezing
 - » Child appears blue around lips or fingernails
- Child who is extremely irritable, is crying uncontrollably or is very lethargic.
- Fever in a young infant (less than 4 months of age).
- Child is confused.
- Seizures or convulsions.
- Severe pain.
- Severe bleeding.

DIAL 911 FOR EMERGENCY HELP.

Post emergency numbers by the telephone along with the address and telephone number of the child care site, as these can be easily forgotten in an emergency.

When calling for emergency help, be prepared to give the operator the following information:

- Your name, address and telephone number.
- Describe the situation or child's condition.
- Child's name, age, any pertinent medical history and parent's name

Chapter 14 **First Aid in Emergencies**

FIRST AID KIT

Keep a stocked first aid kit in a convenient location that is known to all staff. The kit should be out of reach of children. Assign one person to check it regularly and restock it as necessary. You should also have a first aid kit in any vehicle used for transportation or field trips.

SUPPLIES

- List of important local emergency telephone numbers, including police, fire, EMS and Poison Control
- First Aid Quick Reference Guide (American Academy of Pediatrics, American Heart Association or equivalent)
- Disposable nonporous gloves – minimum of two pair
- Scissors
- Tweezers
- A nonglass thermometer to measure a child's temperature
- Bandage tape
- Sterile gauze pads
- Flexible roller gauze, 2 inches and 4 inches
- Triangular bandages
- Absorbent compress
- Safety pins
- Eye dressing
- Pen/pencil and note pad
- Cold pack
- Water
- Small plastic or metal splints
- Liquid antibacterial soap
- Adhesive strip bandages
- Plastic bags for disposing of materials used in handling blood
- Any other supplies needed to conform to facility policies and/or child care licensing regulations

NOTE: Ointments, first aid sprays or other medications should not be used without the written, signed authorization of a physician and parent.

GLOVES

Put on clean, disposable gloves if you expect to come into contact with blood; for example, if you care for a bloody nose or cut or clean a spill that has blood in it.

After you finish, throw away the soiled gloves, bandages, paper towels, etc., in a plastic bag and wash your hands.

If, in the confusion of the moment, you forgot to put on gloves, do not panic! But do wash the parts of your body exposed to the blood. Washing will reduce the risk that any virus or bacteria that may have a chance to enter your body through a cut or break in your skin.

YOUR RESPONSE DURING EMERGENCIES:

While help is being summoned, give immediate attention to the following first aid priorities:

IF YOU DETERMINE THAT A MEDICAL EMERGENCY EXISTS:

TREAT LIFE THREATENING PROBLEMS FIRST

- Make sure the scene is safe for you and the child.
- Remove child if in immediate danger, e.g., fire or gaseous fumes.
- Call 911.
- Start CPR if child is unresponsive.
- Control severe bleeding (use gloves if available).
- Notify parents.
- Appropriate personnel should remain with the child until help arrives.

EVALUATE GENERAL CONDITION

- Avoid moving child until initial assessment is done.
- Assess child from head to toe.
- Determine if child is alert enough to respond to commands (conscious or unconscious).
- Find out what happened and the extent of child's injury.

THINK OUT A COURSE OF ACTION AND FOLLOW IT THROUGH

- Use calm, reassuring manner.
- Speak quietly and avoid making negative comments about the situation or child's condition.
- Avoid unnecessary wound contamination. Wash your hands!
- Refer for further evaluation and treatment.

Chapter 14 **First Aid in Emergencies**

CONSULT WITH PARENTS

- **Parents should be notified of all injuries.**
- Immediate notification should be determined by the extent of the injury and the condition of the child.

DOCUMENTATION (incident report and additional recording)

- Describe incident, observations, date and time.
- Outline course of action taken.
- List persons notified (e.g., parents, doctor and supervisor).
- Review the incident with all staff and determine whether there are ways to prevent reoccurrence.
- Encourage parents to keep immunizations up to date.

SHOCK

SIGNS AND SYMPTOMS:

- Child feels weak, faint or dizzy.
- Child has pale or grayish skin.
- Child acts restless, agitated or confused.
- Skin is cold and moist to the touch.
- Sometimes occurs after bad allergic reaction or loss of a lot of blood.

TREATMENT:

- Keep child lying down.
- Offer calm reassurance.
- Elevate legs.
- Do not give food or fluid.
- Maintain body temperature – add blankets if indicated.

(Injuries are listed in alphabetical order from this point on.)

BITES AND STINGS

HUMAN OR ANIMAL BITES

- Cleanse wound thoroughly with soap and running water unless there is tissue loss or severe bleeding. In that case follow severe wound first aid instructions.
- Apply a sterile dressing and immobilize bitten area.
- If there is a bruise or swelling, place an ice bag wrapped in a towel on the bite for up to 20 minutes.
- Stay away from any animal that is acting strangely. An animal with rabies can bite again.
- Report all animal bites to police and/or animal control – provide animal description and last location.
- Notify family or guardian so that medical professionals can be consulted.

INSECT BITES AND STINGS

Some insect bites can be serious and even fatal if the child has a bad allergic reaction to the bite or sting or if venom is injected by a poisonous spider. Watch the child for at least 60 minutes after a bite or sting and call 911 if you see any of these signs after a sting or spider bite:

- Trouble breathing
- Swelling of the tongue or face
- Fainting
- Severe pain at the bite site
- Muscle cramps
- Vomiting or fever
- Seizures
- Unresponsiveness

Bee stings and spider bites

- Scrape off bee stinger if present, using a credit card or dull knife.
- Cleanse with soap and water.
- Apply ice bag wrapped in a towel on the bite.

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Ticks

- Remove **all** of the tick with tweezers by grasping close to point of insertion. A small tag of skin may be attached.
- Wash area well with soap and water.

SNAKE BITES

- Call 911.
- Keep the child calm and still.
- Tell child not move the part that was bitten.
- Gently wash the bite area with running water and soap if available.
- Remove any jewelry near the bite (risk of swelling).

BLEEDING

MINOR WOUNDS

- If possible, before administering first aid, wash your hands with soap and water and use gloves.
- Cleanse wound thoroughly with **soap and water only**; rinse and dry well.
- Apply a sterile bandage or dressing.

SEVERE WOUNDS (deep cuts; gaping wounds)

- Use gloves when available. Control bleeding by applying direct pressure, using a sterile dressing and the palm of your hand. If these dressings become saturated – **do not remove** – reinforce with additional dressing.
- Amputated parts (finger, ear, foot, etc.): Rinse part in clean water, cover/wrap in clean dressing.
 - » Put into a clean plastic bag.
 - » Place that bag in another container of ice or ice water.
 - » Label with child's name, date and time.
 - » Send the part with the child to the hospital.

BONE-JOINT INJURY

- Inspect fracture.
- Do not move the injured part.
- Support the injured part (pillows, clothing or splints).

- Control bleeding.
- Apply sterile dressing if open wound.
- Apply ice bag wrapped in towel.
- Observe for shock.

BRUISES

- Apply ice bag wrapped in a towel.
- Call 911 if the injured part is abnormally bent or is severely painful or if you are not sure what to do.

BURNS

SMALL BURNS (redness with mild swelling and discomfort)

- Cool the burn area immediately with cold, but not ice cold, water.

LARGE OR BLISTERED BURNS (red matted appearance with blisters, swelling, wet appearances of skin surface)

- Call 911 for large burns, electrical/chemical burns or shock or if you are unsure what to do.
- Cool the area with cold water as above until pain has subsided; blot dry.
- Apply dry sterile dressing.
- **Do not** break blisters.
- **Do not** apply medication, ointment or any household product on a burn.
- Burns on hands, feet, face or genitalia should receive prompt medical attention.
- Elevate if on arms or legs.
- Contact parent, regarding medical referral for treatment.

CHEMICAL BURNS

- Wash away the chemical with large amounts of water for at least five minutes. Remove affected clothing.
- First aid treatment for acid burns of the eye should begin as quickly as possible. Flush affected eye with water from the inner corner outward for 15 minutes. **Do not** allow chemical to contaminate unaffected eye.

CHOKING ON SMALL OBJECTS (FIRST AID FOR AIRWAY OBSTRUCTION)

START CPR AND/OR CALL 911.

Choking infant (less than 1 year):

- Hold infant facedown on your forearm. Support the infant's head and jaw with your hand. Sit or kneel and rest your arm on your lap or thigh.
- Give up to five back slaps with the heel of your free hand between the baby's shoulder blades.
- If the object does not come out after five back slaps, turn the infant onto his or her back. Move or open the clothes from the front of the chest only if you can do so quickly. You can push on the chest through clothes if you need to.
- Give up to five chest thrusts using two fingers of your free hand to push on the breastbone in the same place you push for compressions, supporting the head and neck. Hold the infant with one hand and arm, resting your arm on your lap or thigh.
- Alternate giving five back slaps and five chest thrusts until the object comes out and the baby can breathe, cough or cry or until the infant stops responding.

Choking children over 1 year and adults: (*Heimlich maneuver*)

- Ask "are you choking?" If yes, offer help.
- Kneel or stand behind person and wrap arms around so that your hands are in front.
- Make a fist with one hand.
- Put the thumb side of your fist slightly above person's navel and well below the breastbone.
- Grasp the fist with your other hand and give quick upward thrusts into the abdomen.
- Give thrusts until the object is forced out and person can breathe, cough or talk; until person stops responding; or until trained help arrives.

CONVULSIONS/SEIZURES

- Keep calm.
- Do not try to restrain or put anything between the teeth.
- Protect the child from injury – clear the area.
- Call 911 if this is the child's first seizure or if you are unsure.
- When the seizure is over, let the person rest – turn person on side or turn head to side.
- Following the seizure, observe for absence of breathing and start CPR if needed.

DENTAL INJURIES

Treatment of Dental Problems in the Child Care Setting

Dental problems for children can range from mild inflammation of the gums (gingivae) to traumatic tooth loss or even jaw fracture. Fortunately, most dental problems that arise in the child care or academic setting can be handled by competent staff. However, some conditions will need the attention of a dentist as soon as possible.

Inflamed or Irritated Gum Tissue

Red, inflamed or even bleeding gums are most likely caused by poor oral hygiene. Diligent removal of plaque by regular brushing will allow the gums to heal until they regain their normal color and tone. Less frequently, inflamed gum tissue may be caused by vitamin deficiency or other systemic problem. If the tissue does not respond to regular brushing or flossing, the child should be referred to his/her dentist for evaluation.

Cold Sores, Fever Blisters and Canker Sores

These infections are usually not serious, and the only required treatment is to keep the child comfortable without irritating the affected areas. A child's first infection with the *Herpes simplex* virus (responsible for cold sores and fever blisters) may leave the child with a fever and feeling sluggish, with widespread sores in and around the mouth.

Appropriate treatment with Tylenol® or other non-aspirin pain reliever may be indicated, consistent with child care center policy. Subsequent *Herpes* virus infections appear as cold sores or fever blisters, usually at the corner of the mouth. Ensure that the child does not rub or scratch at the sore because it may become further infected. With or without treatment, these sores will usually disappear within two weeks.

Canker sores are red-rimmed white lesions located inside the mouth on the oral soft tissues. Canker sores are extremely sensitive to spicy or acidic foods. Choose foods for the child that will not irritate these areas. If appropriate under child care center policy, small amounts of Orabase® with Benzocaine can be applied to the sores, after meals and before nap time.

NOTE: Aspirin containing pain relievers are not recommended for use in children. Even in adults, aspirin should never be placed on a tooth or sore in the mouth; the aspirin will actually burn the tissue!

Toothaches

Toothaches can be caused by many different problems but are most common due to tooth decay (dental caries) or gum (gingival) infections. Other causes can include food or objects trapped between teeth. Pain of the upper teeth, usually not specific to any one tooth, can be due to sinus infection. This type of infection is usually more severe when the child bends over and may even make all the upper teeth throb.

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For tooth or gum pain, first rinse the mouth vigorously with warm water to clean away any debris. Use dental floss to remove any food trapped between teeth. If swelling is present, apply a cold compress to the outside of the cheek. Non-aspirin pain reliever may be given to relieve pain, consistent with child care center policy. Pain that appears to be caused by decayed teeth or large swelling of the gums should be treated as soon as possible. Contact the child's parents and refer the child to the dentist.

Prolonged or Recurrent Bleeding After Tooth Loss or Extraction

Teeth extracted, or even baby teeth lost normally, sometimes will cause continued bleeding long after the tooth is removed. After a tooth is removed, ensure that the child does not rinse with liquids for 24 hours.

If bleeding persists or recurs, place 2 inch x 2 inch sterile gauze on the extraction site and have the child bite on it for 30 minutes. Replace the gauze with a clean one if necessary. If bleeding does not stop within two hours, contact the child's parents and recommend that the child see the dentist immediately.

Tooth Eruption Pain

Sometimes even normal loss of baby teeth can be uncomfortable for children. If the child seems to be in pain from a tooth being shed, try to determine if the pain is from a loose baby (primary) tooth pinching the gum or due to a permanent tooth coming into the mouth.

Prolonged pain (more than one week) is unusual and may be caused by infection in the gum tissue. Pain from new teeth coming into the mouth is usually intermittent and less painful than the pain associated with badly decayed or abscessed teeth. If pain persists, have the child's parents contact their dentist.

Discomfort can be managed by use of non-aspirin pain relievers, consistent with child care center policy. Especially for infants and toddlers, letting the child eat something cold may alleviate the pain.

Broken or Displaced Teeth

If teeth are broken or moved within the socket, first try to clean any soil, blood or other debris from the injured area with a cotton swab and warm water. If swelling is present, apply a cold compress on the cheek next to the injured tooth. Evaluate for displaced teeth by having the child bite gently together. See if any teeth seem to be out of their normal alignment. If the tooth appears to have been moved or pushed farther into its socket, refer the child to a dentist for evaluation and treatment.

If a tooth is broken, the sharp edge may be covered with soft wax to prevent cutting the lips or tongue. Contact the child's parents and refer the child to the dentist as soon as possible.

Tooth Loss (Traumatic Avulsion)

If a permanent tooth is knocked out, you must act immediately. Time is of the essence for successful treatment. Look in the immediate area of the accident to locate the missing tooth. If found, do not try to clean the tooth. Washing or wiping it could remove the connective fibers that will help anchor the tooth when it is replaced.

Contact the parent if possible and get the child to the dentist within 30 minutes. Wrap the tooth in a moist paper towel or gauze and be sure the tooth goes with the child. Delays in seeking treatment will greatly affect the success of replacing the tooth.

Jaw Fracture or Dislocation

Dislocation of the lower jaw is not often a true emergency – although dislocation can be extremely uncomfortable, it is not life threatening. However, untrained persons may not easily tell the difference between a suspected dislocation and a jaw fracture. Therefore, both suspected dislocation and fracture should be treated with the same sense of urgency.

After a trauma, jaw fractures or a dislocated jaw are commonly recognized because the child's teeth no longer bite together normally. If a fracture or dislocation is suspected, immobilize the jaw by any means possible. Place a towel, scarf, handkerchief or tie under the chin and tie the ends on top of the child's head. Only tie tightly enough to prevent jaw movement.

Contact the child's parents and arrange for the child to be taken to the dentist or oral surgeon immediately. If the child must go to the hospital emergency room, the child should be seen by an oral or maxillo-facial surgeon or an orthopedic or plastic surgeon.

BE PREPARED

The management of dental emergencies can be done by child care or school staff. However, you must be prepared for these emergencies. Your first aid kit should contain cotton swabs, dental floss, ice packs or cold compresses, soft wax, and sterile 2 inch x 2 inch gauze pads. Orabase® with Benzocaine and non-aspirin pain relievers may be used, but their use must be consistent with your child care center's policies and parental permission as appropriate.

Proper handling of dental emergencies in the child care setting will not only relieve pain and discomfort, but it may also ensure that the children in your care have a smile they can be proud of for a lifetime.

For more information, please contact the Office of Oral Health at the Arkansas Department of Health, 501-661-2595.

EYE INJURIES

- If child is hit hard in the eye or if the eye is punctured, call 911 and the parent; cover eye with clean, dry dressing. Have child keep eyes closed if possible and stay with child until help arrives.
- If eye is mildly irritated (e.g., with sand particle, eyelash, etc.), flush affected eye with water from the inner corner outward for 15 minutes.
- If object does not come out or if child is in extreme pain, call parent or health care provider. Ask child to keep eyes closed until trained help arrives.

HEAD/SPINAL INJURIES

Suspect a head or spine injury if a child:

- Fell from a height
- Was hit on the head or upper body
- Was hit by falling object or forceful blow to head or chest
- Was involved in a car or bicycle accident
- If a baby was shaken (reportable to Child Abuse Hotline)

Signs of a head or spine injury:

- Does not respond or only moves or moans
- Is sleepy or confused
- Vomits
- Complains of a headache, neck/back pain, tingling or weakness in arms/legs
- Has trouble seeing
- Has trouble walking or moving any part of the body
- Has a seizure

Actions for head, neck and spine injuries:

- Make sure the scene is safe.
- Call 911.
- Hold the head and neck so that they do not move, bend or twist.
- Only move the child if he or she is in danger, if you must open airway or if child is vomiting.
- Start CPR if child is not responsive and if you know how.

POISON INGESTION

Contact:

The emergency phone number for most areas is:

911

The toll-free phone number for the Arkansas Poison Control Center is:

1-800-222-1222

Remember to place this Poison Hotline number in your cell phone's speed dial and somewhere conveniently located so you can see it. The Arkansas Poison Center is available 24/7 and is staffed with licensed doctors, pharmacists and registered nurses. Whether someone has ingested an extra dose of medicine or swallowed a cleaning substance or you just have a poison question, feel free to call! You will speak to a live person in two rings or less each time! A caring voice on the other end of the line is always eager to help you through any poisoning situation, so remember to call if you need to.

Be sure to:

Follow the Poison Control directions.

Take the container with you when you call. Poison Control may need information from the label.

Give Poison Control your telephone number in case you are disconnected.

Don't hang up until instructed.

Contact parent.

References:

American Heart Association Heartsaver Pediatric First Aid handbook

Arkansas Poison Control

Caring for Our Children: National Health and Safety Performance Standards; Guidelines for Out-of-Home Child Care, 2nd Edition

www.healthychildcare.org





ARKANSAS HEALTHY CHILDREN HANDBOOK

6TH EDITION • 2012

Chapter 15 Inclusion of Children with Disabilities

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Successful Inclusion



**ARKANSAS DEPARTMENT OF
HUMAN SERVICES**



Division of Child Care and Early Childhood Education

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ARKANSAS HEALTHY CHILDREN HANDBOOK

Chapter 15 Inclusion of Children with Disabilities

We hope this guide will help accomplish having every young child with a disability and their family feel affirmed and supported for who they are and what they have to offer. To achieve this result, we must view a child with a disability first and foremost as a child, with a unique personality, abilities, likes and dislikes. This guide will be useful to all those who have just begun to reach out to and serve children with more significant disabilities and programs that have considerable experience.

This guide will lay the groundwork for inclusion, helping all those invested in early childhood services to develop a broader view of their roles and set the stage for collaboration to meet the needs of all children. In the following three sections, inclusion will be defined and discussed, effective communication techniques emphasized, and an overview of laws and regulations as they impact young children with disabilities and their families will be outlined. We hope that these materials will strengthen your capacity to reach and include children with disabilities and their families.

References

Setting the Stage: Including Children with Disabilities in Head Start and Training Guides for the Head Start Learning Community. (This national training guide was developed by Education Development Center, Inc., 55 Chapel Street, Newton, MA 02158-1060, under contract number 105-93-1583 of the Head Start Bureau, Administration for Children and Families, Department of Health and Human Services.)

ABOUT INCLUSION

(Four-year-old Jenny watches as Danny, a classmate, carefully traces his hand with a neon green marker. Jenny's arms end at her elbows.)

"Wanna borrow my hand?" Danny asks her.

"That's okay," Jenny says, "I'll use my own."

Then they both trace their hands together.

PURPOSE

Increasingly, this is becoming a typical scenario as child care programs are reaching more children with significant disabilities. Jenny and Danny are not just in the same classroom – they are also playmates. While the teacher observes the exchange, she does not interfere. She does not need to because she, along with other staff and families, has laid the groundwork for this kind of interaction. Together, they have created a climate that fosters appreciation and understanding of individual differences.



Chapter 15 Inclusion of Children with Disabilities

While early childhood settings have long been a mainstreaming placement for children with disabilities, today the focus is on inclusion. This means not only allowing children with disabilities to be in close proximity to their typically developing peers but also maximizing their full participation in the program. Just being in the same classroom does not automatically make a child with a disability a valued member of the group. Programs must create environments that are responsive to the diverse needs of all children.

Inclusion is a philosophy driven by the belief that individuals with disabilities can and should be integrated into all aspects of community life. The Division of Early Childhood of the Council for Exceptional Children defines inclusion as:

“A value that supports the right of all children, regardless of their diverse abilities, to participate actively in natural settings within their communities. A natural setting is one in which the child would spend time had he or she not had a disability. Such settings include but are not limited to home and family, play groups, child care, nursery schools, Head Start programs, kindergartens, and neighborhood school classrooms (1993).”

WHAT DOES INCLUSION LOOK LIKE?

Research and practice tell us that when a classroom is truly developmentally appropriate, it can meet the needs of children with varying abilities. However, because children with disabilities have unique needs, they will often require additional services and support if they are to be fully included. Some necessary supports may be costly, while others may be relatively inexpensive or even free (e.g., asking community groups such as the Kiwanis Club or churches to make donations or lend equipment). Others may require some creativity on the part of staff (e.g., gluing corks on puzzle pieces to serve as handles, rearranging the physical space or the schedule).

But what does it mean to be fully included? The following table illustrates some examples that highlight the differences between inclusive and restrictive settings. Inclusive practices draw each child into active participation with other children. Adaptations and adjustments may be necessary, but as staff and families work together, solutions can be found and the overall program for all children enhanced.

INCLUSIVE/RESTRICTIVE PRACTICES

Area	Inclusive Practices	Restrictive Practices
Delivering Special Services	Specialist provides services in the context of the child's regular classroom. Working with a small group of children (including those who need special services), the therapist provides intervention through a fun activity such as playing a game.	Specialist pulls the child with a disability out of the classroom to provide services in a resource room or therapist's office.
Mealtime	Staff uses mealtime as opportunities for social integration for all children. For example, one teacher provided adaptive equipment – a plate with a suction cup that sticks to the table and a bent spoon to make eating an easier task for a child with cerebral palsy.	Children who use adaptive equipment eat at a “special table” with a staff person.
Toys, Posters and Other Materials	Classroom materials include images of individuals with disabilities. These images focus on the individuals and their activities and capabilities; their disabilities are incidental.	There are few images of individuals with disabilities. When there are images, the focus is solely on the disability.
Classroom Setup	The physical setup of the classroom promotes exploration and social interaction. Classroom materials are arranged so that they are accessible for all children, including children with disabilities. Furniture is arranged so that children who use special equipment can move around the room easily.	Most of the classroom materials are accessible only for adults and typically developing children. They are out of reach of children who cannot stand or walk independently.
Parent/Staff Relationships	Staff actively seeks all parents' input in planning program-wide activities, problem solving and decision making.	Staff speaks to parents only when problems arise or when a special education decision must be made.
Working with Adults with Disabilities	The program has an open hiring process, recruiting people with disabilities. The program also works actively to involve parents with disabilities. Extra supports are provided as needed (e.g., locating someone who can interpret for a parent who is deaf).	No adults with disabilities work in the program. No attempts are made to include parents with disabilities in the program.



HOW DOES INCLUSION BENEFIT CHILDREN AND FAMILIES?

Inclusion can benefit children with disabilities by helping them:

- Build friendships with typically developing peers from their own communities and neighborhoods. The ability to build friendships in the early years is a key to establishing relationships in later life.
- Receive services and supports in the context of their regular classroom without being isolated.
- Learn in the company of their peers.
- Develop the social competence they need to become active leaders.

Including children with disabilities also benefits their families by helping them:

- Build connections with other families in the community.
- Realize that their children who have disabilities can succeed in regular classrooms and that they will continue to receive the necessary support services.
- Appreciate that their children can benefit when they play alongside peers.
- Learn about diversity and about the strengths that different people have.

Including children with disabilities also benefits children with more typical development and their families by providing opportunities to:

- Interact with children and families in their community whom they might otherwise not meet.
- Develop a greater understanding and respect for persons with disabilities.
- Build a stronger sense of social responsibility.

Inclusion also benefits child care staff by providing opportunities to:

- Interact with children who have a range of abilities.
- Learn from specialists who can provide information, skill building and support for tapping the strengths of individual children.
- Plan and implement children's educational programs.
- Build a collaborative partnership with specialists, parents, and other staff and services.

As you read about the benefits of inclusion, you should notice that it's not just the young child with a disability who benefits but also their classmates as well as the families of all of the children. As children grow into adulthood, their attitudes and actions toward people with disabilities will be shaped by their early experiences. Positive experiences in inclusive settings will enable them to view a person with a disability as a real person with their own unique personality, gifts and abilities.

Inclusion, though beneficial, does not occur without careful planning and thoughtful interaction between staff and families. In the next section, effective strategies for communication, which lays the foundation for inclusion, will be discussed.

COMMUNICATION COUNTS

Whenever we communicate, in words or actions, we express our attitudes, values and beliefs. Simple words and gestures can make people feel included or left out. For most staff, reaching out, communicating respectfully and building community just comes naturally. However, there are times when we may “forget” how to communicate with respect, especially when we are afraid of saying something that might offend someone.

Background Information

Constructive communication requires both skill and “heart” – respect, empathy and caring. By recognizing ways in which our communication fosters or hinders inclusion and practicing communication that promotes a sense of belonging, each of us will enhance our ability to welcome and support all children and families.

VIGNETTES OF A CHILD WITH A DISABILITY, HIS OR HER MOTHER, AND STAFF

“My name is Maggie and I have a four-year-old son named Joey. Joey loves Batman, tadpoles and karate. He likes painting and using his hammer, too. He has a great sense of humor and other kids usually like him. He has not attended school yet but is eager to go. Right now, Joey needs a wheelchair to get around.

“We hope Joey will be able to walk someday, but we’re not sure it will ever happen. Other things will probably last forever. He is blind in one eye and he wears a patch over it. One side of his face looks lopsided; he drools, and sometimes it takes him longer to understand what’s going on. He’s still Joey, though, and even though his right arm shakes a bit, he can still swing his hammer.

“I want Joey to be just like any other kid, and I want both of us to be treated like any other parent and child.”

With this introduction to Maggie and her son, Joey, several vignettes are available that describe how different individuals respond both to Joey and to Maggie. As you read each vignette, think about the communication that is occurring and answer the following questions:

- ***How would you feel if you were Maggie?***
- ***How would you feel if you were Joey?***



Chapter 15 **Inclusion of Children with Disabilities**

Vignette 1: Enrolling Joey

I saw a notice in the doctor's office about an opening in a child care program. It even said something about accepting children with disabilities. I went to the office and filled out some forms. I also spoke with a family worker. At the end of our conversation I told her about Joey's disabilities. She looked nervous and said:

"That's fine. I'll have someone call you to talk about whether this program is really the best place for him."

Vignette 2: A Visit to Our Home

A new home visitor came out to see us yesterday. She came in and asked me how things were going with Joey. I asked her if she had met Joey yet or if she knew about Joey's special needs. She said:

"I know he has neurological problems, but I have not had the chance to meet him yet."

I called Joey into the room. She squatted down and said hello to him. She looked him in the eye and put out her hand to shake his hand. Then she said:

"How do you like going to the center, Joey?"

Vignette 3: A Surprise Meeting

On the first day of the program, I went along. We met the assistant teacher in the hallway. She seemed happy to talk to me. But she never once spoke with Joey. It was like he wasn't even there.

When she asked me, ***"What does Joey like to do?"***

I said: ***"Oh, you'll need to ask Joey that one."***

Vignette 4: Riding the Bus

From day one, the bus driver treated Joey and me like regular people. She almost always has something good to tell me about Joey, such as;

"He has a great sense of humor."

or

"He is so generous with other kids."

I can tell that even though she only spends a short time with him each day, she has gotten to know him and has a relationship with him. She even corrected him today in front of me for trying to use karate on another boy!

Vignette 5: The Appointments

I had a meeting with the disabilities services coordinator, someone I hardly know. She seemed nice enough, but she asked me so many questions about Joey, such as;

“Was he born this way?” “Has he gotten worse over time?” “What doctors does he see?” “What support do you need?”

I know she was trying to help, but it was too much, and I hardly know her. She didn’t seem to want to get to know ME or JOEY, just things about his disabilities.

Vignette 6: The Cook

As we were leaving today, we met one of the cooks in the parking lot. I didn’t know him, but Joey did. They smiled at each other and waved hello. He came over and introduced himself to me. He seemed a bit uncomfortable and said:

“Joey and I are buddies. I don’t know much about Joey’s problems, but, if I can make Joey something special or help out, just let me know.”

Vignette 7: The Volunteer

One day I was at a parent workshop and a new volunteer came up to me. She told me she spent time in Joey’s classroom and that she liked Joey a lot. She also said:

“I gave Joey a special treat because I felt so sorry for him.”

COMMUNICATION THAT FOSTERS INCLUSION

As you noticed in the vignettes, communication can support the feeling of really being included or it can make the person with the disability and his or her family feel different and apart from others. Inclusion is becoming an active part of – not separated from – other children and families. In the information that follows, we’ll look at how the vignettes illustrate communication that fosters or hinders inclusion and some of the mother’s insights into how she perceived the interaction and how it made her feel.

Your communication will foster inclusion if you:

- See the person first, not the disability.
 - » **The Home Visitor.** She squatted down and said hello to him. She looked him in the eye and put out her hand to shake his hand. Then she said, ***“How do you like the Center, Joey?”***
- Focus on the whole child.
 - » **The Bus Driver.** She almost always has something good to tell me about Joey, such as: ***“He has a great sense of humor,”*** or ***“He is so generous with other kids.”***



Chapter 15 **Inclusion of Children with Disabilities**

- Treat the child and family the same way you treat all families. Get to know each of them as individuals.
 - » **The Disabilities Service Coordinator.** She asked a lot of intrusive and personal questions, but she didn't take time to get to know me (Maggie) or Joey.
- Listen to them. Don't make assumptions about what they want or need. Get to know their strengths. Don't make exceptions because you feel sorry for them.
 - » **The Volunteer.** She gave Joey a special treat because she felt sorry for him. She meant well, but Joey should not be treated differently than the other children when treats are available.
- Be genuine.
 - » **The Cook.** He came over and introduced himself to me. He seemed a bit uncomfortable and said: ***“Joey and I are buddies. I don’t know much about Joey’s problems, but if I can make Joey something special or help out, let me know.”***
- Show by words and actions that you care – that you accept, respect and support them. Empathize. Listen and understand from their point of view.
- Know about the rights of people with disabilities so you can be an advocate in the program and the community.
- **The Family Worker.** She indicated that she didn't know whether their program was really right for Joey. This was not her decision and she should have been knowledgeable about the rights of children with disabilities.

Responding to questions may pose a challenge. However, the response will either foster a sense of belonging and respect or further set the child with a disability apart from the group.

Answers that *foster a sense of belonging* to the group are:

- Responsive
- Nonjudgmental
- Focus on the whole child and not the disability
- Sensitive
- Honest
- Appropriate to the developmental level of the person asking
- Respectful
- Genuine and caring, not just trying to use the “right” words
- Given in a way that acknowledges and respects the family's values
- Protective of a child's and family's rights to privacy

- Geared to ensure that the rights of persons with disabilities are known and respected by others in the program and the community

Answers that *hinder a sense of belonging*, even if well intentioned:

- Are overprotective
- Avoid the question
- Blame the person asking
- Focus on the disability and not the person
- Focus on the law as the only reason to fully include persons with disabilities
- Make generalizations about persons with disabilities
- Have the “right” words in them but not the feelings and attitudes that convey respect and dignity

WORDS ARE THE ONLY THINGS THAT LAST FOREVER

People with disabilities know all too well that words create opportunities or build barriers. Man or woman, adult or child, it is something they deal with every day of their lives. For too long words have been used to separate and isolate people with disabilities. They have heard them all: idiot, retard, handicapped, fragile, mentally weak, weird, deformed, moron, dumbbell, brain dead, imbecile, cripple, mongoloid, spastic, feeble minded, brain damaged, drip, stupid, and on and on and on...

Watch your thoughts for they become words. Choose your words for they become actions:

- Time after time people with disabilities have been identified not as a person but as a problem. They’ve heard terms such as afflicted with, crippled by, suffers from and a victim of. They’ve been pitied or praised because of their “battle” to overcome their handicap.
- To paraphrase writer George Orwell, if thought corrupts language then language can corrupt thought. Put another way, the words we choose reflect our attitudes.
- That’s why people with disabilities prefer “*people first language*.” What, exactly, is people first language? Simply put, people first language uses words in a way that identifies the person before their so-called problem.
- The formula is simple – put the person before the problem, and you get a positive perception.
- This, people with disabilities will tell you, is the first step toward full acceptance as contributing members of society. It is one of the ways they can let their fellow citizens know that they are not broken – that for them being disabled is a natural, not a selected, way of life.



Chapter 15 **Inclusion of Children with Disabilities**

- People first language also prevents the tendency to reduce the person to the disability. When words alone define a person, the result is a label...a label that almost always reinforces the barriers created by negative and stereotypical attitudes.
- As the nation's last minority, people with disabilities know something most of us fail to recognize – what you see is not necessarily what you get. While people with disabilities and their advocates are working hard to end the very real discrimination and segregation in education, employment and participation in community activities, all of us must strive to eliminate the prejudicial language that creates barriers to inclusion in the mainstream of society.

We cannot always control our thoughts, but we can control our words.

- Like paint on a canvas, words create a powerful image. The question is whether we want that image to be a straightforward, positive view of people with disabilities or an insensitive portrayal that reinforces common myths and is a form of discrimination.
- And one more thing – let's not talk about "special needs" anymore. The needs of a person with a disability aren't special to him or her.
- Source of information: Arkansas Governor's Developmental Disabilities Council

SPEAKING WITH PEOPLE WITH DISABILITIES

When speaking to people with disabilities, there are some common sense courtesies that will assist both participants to feel both comfortable and respected. These suggestions have been developed by people with disabilities. After all, it is people with disabilities who have had extensive experience with both positive and negative communications:

- Ask if assistance is needed rather than assuming it is. Then follow the instructions of the individual to avoid possible injury to the person or yourself.
- Don't assume that a person with one disability also has others.
- Maintain eye contact and talk to the person even if he or she is using an interpreter.
- When speaking with a person who has a speech impairment or uses an augmentative communication system, be patient and give the person time to respond to your question. Don't try to finish a sentence for the person. If you don't understand what the individual has said, say so and ask him or her to repeat the statement or say it another way.
- Use a normal tone of voice. Speaking loudly causes pain for some people.
- Do not lean on a person's wheelchair or distract a working animal. Don't "play" with assistive equipment.
- Don't hesitate to use everyday expressions. It's fine to say, "See you later," to a person who is visually impaired, or "Let's take a walk," to a person using a wheelchair.

**Adapted with permission from Developmental Disabilities Council.*

"Choosing Words with Dignity." Concord, N.H.: Developmental Disabilities Council.

A FINAL WORD

One more time, put the person first when writing or speaking about people with disabilities. Stay away from labels such as the blind, the deaf or the disabled. They do not reflect the individuality, equality or dignity of people with disabilities. So, with all this in mind, when referring to a person with a disability...

Say or write this...	Instead of this!
She is a person with a disability.	She is handicapped or disabled.
He is an individual without a disability.	He is able-bodied.
They are children (kids) without disabilities.	They are normal or healthy children (kids).
He is a person with a cognitive disability.	He's retarded.
She is an individual with autism.	She's autistic.
He needs behavior supports.	He has behavior problems.
She is a person with a learning disability.	She's learning disabled.
He uses a wheelchair.	He's confined to a wheelchair.
She has a physical disability.	She's a quadriplegic or a cripple.
He has a brain injury.	He's brain damaged.
She has a congenital disability.	She suffers from a birth defect.
He is a person with mental retardation.	He's a retard or mentally defective.
She is a person who is blind or visually impaired.	The blind.
He is a person who is deaf or hard of hearing.	He suffers a hearing loss or from being deaf.
She is an individual with (or who has) multiple sclerosis or muscular dystrophy.	She is afflicted by MS or MD.
He is a person with cerebral palsy.	He is a victim of CP.
She is an individual with epilepsy.	She is an epileptic.
He is a person with a psychiatric disability.	He is crazy, nuts, etc.
She is a person who no longer lives in an institution.	She is deinstitutionalized.
He is a person who uses an assistive speech device or is unable to speak.	He is dumb or a mute.

The old rhyme that says, “**Sticks and stones will break my bones, but names will never hurt me,**” is somewhat inaccurate. Names, labels and degrading statements can and do **hurt**. Consideration, courtesy and dignity should guide our interactions with all children and their families, including children with disabilities and their families.



MAKING IT WORK

BACKGROUND INFORMATION

Laws and regulations about the rights and protections of children and adults with disabilities have been enacted over the years. These laws provide a mandate to end discrimination against individuals with disabilities. They also protect individuals' essential right to participate in the community and have access to critical services. This guide will help participants understand the principles underlying these laws and regulations and how these principles apply to everyday practice.

It takes much more than awareness, sensitivity and commitment to promote belonging for children with disabilities. It also takes resources – money, personnel and materials. Child care staff, along with families and other service providers, must be able to solve problems and bring specific ideas to the table. Inclusion also requires that children get the extra support they need, such as special services and environmental adaptations. But first, staff needs to understand the principles underlying the laws and regulations that protect the rights of children and adults with disabilities.

WHAT LAWS AND REGULATIONS ARE IMPORTANT IN THE AREA OF INCLUSION?

SECTION 504 OF THE REHABILITATION ACT OF 1973

In September 1973, Congress passed Section 504 of the Rehabilitation Act, which prohibits discrimination on the basis of a physical or mental disability. This legislation applies to every program or activity in the country that receives federal money.

AMERICANS WITH DISABILITIES ACT (ADA)

The ADA, which was signed on July 26, 1990, provides “comprehensive civil rights protections to individuals with disabilities in the areas of employment, public accommodations, state and local government services and telecommunications.” This legislation extends the requirements of Section 504 to all public and private programs and provides a mandate to end discrimination against individuals with disabilities. In compliance with Section 504, child care programs must continue to ensure accessibility to program facilities and services for persons with disabilities, including staff, parents, children and collaborating agencies. This law does not apply to sovereign nations.

NOTE: Both Section 504 and ADA are two major laws that protect children and adults from discrimination.

INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA)

This law, reauthorized in 2004, reaffirmed that all children with disabilities ages 0 through 21 have the right to a free, appropriate, public education (FAPE) in the natural (NE) or least

restrictive environment (LRE). Children are eligible for services if they are evaluated by a team and diagnosed as having a disability according to one or more of IDEA's diagnostic categories. Children between the ages of 0 and 5 have the right to receive services without labeling.

Children with disabilities and their families have a right to a coordinated, multi-agency approach to services. Therefore, collaboration between child care programs, Local Education Agencies (LEAs), government agencies (federal, state and local) and other community resources is essential. Besides serving as a partner with LEAs in coordinating services for children with disabilities, child care programs must also take an active role in helping children with disabilities make the transition into school-age programs.

Provisions of IDEA include the IFSP or IEP, parents as co-decision makers, due process, confidentiality and services in the natural or least restrictive environment.

** Adapted with permission from National Network of Resource Access Projects for Head Start. 1995. "Child to Child: Maximizing Opportunities for Social Integration." Washington, D.C.: U.S. Department of Health and Human Services, Administration for Children, Youth and Families.*

WHAT ARE THE KEY PRINCIPLES UNDERLYING THE LAWS AND REGULATIONS?

NONDISCRIMINATION

It is a basic right, not a privilege, for individuals with disabilities to have opportunities to participate fully in school, the community and the workplace. Too often society views accommodations to individual needs as gifts or favors. This suggests that the person who receives the accommodation should be grateful and that the accommodation is optional. However, it is a basic right, not a privilege, for individuals with disabilities to have opportunities to participate fully in school, the community and the workplace. It is, therefore, discriminatory and illegal to exclude children solely on the basis of the type of their disability or the severity of their condition. Furthermore, programs may not refuse to hire or promote persons with disabilities solely because of their disability.

LEAST RESTRICTIVE ENVIRONMENT (LRE)/NATURAL ENVIRONMENT (NE)

LRE/NE children with disabilities have the right to be educated in integrated settings with their typically developing peers whenever possible and beneficial.

Inclusion requires that children get the added supports they need, such as special services and environmental adaptations. Children with disabilities have the right to be educated in integrated settings with children without disabilities in the least restrictive environment. Full inclusion often requires providing those additional services and supports that respond to the needs of children and families.



Chapter 15 **Inclusion of Children with Disabilities**

This means that child care programs must work closely with LEAs and other agencies to ensure that children with disabilities receive the special education and related services they need to succeed in regular education settings. Children cannot be removed from the regular education environment unless their Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP) states that even with extra supports and services their needs cannot be met in a regular classroom/child care setting.

INDIVIDUALIZED EDUCATION PLAN (IEP) OR INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP) AS A CONTRACT

The IEP/IFSP determines the services that the child will receive. The IEP/IFSP serves as a contract, one that cannot be changed unless the team reconvenes and the parent(s) agree with their signature. Every child, ages 0 to 21, who receives special education/early intervention services, must have an IEP/IFSP. The IEP/IFSP includes a written statement of a child's education program. It is developed by a team consisting of the child's parents, teachers and a number of other specialists. The IEP/IFSP determines the services that the child will receive.

The IEP/IFSP serves as a contract, one that cannot be changed unless the team reconvenes and parents sign the revised IEP/IFSP to show their agreement. (If they don't want to sign, the IEP/IFSP cannot be changed.) The Individualized Family Service Plan (IFSP) describes what services infants, toddlers and their families receive.

PARENTS AS CO-DECISION MAKERS

Parents have the right to take part in and approve all educational decisions regarding their children. They indicate their agreement by signing the IEP/IFSP. Parents know more about their children's capabilities and needs than anyone else. Their participation in all aspects of the education process leads to better services and developmental outcomes. Parents have the right to take part in and approve all educational decisions regarding their children.

A parent's signature on the IEP/IFSP is required. If parents ever disagree with their child's evaluation, identification or placement, they have the right to request a due process hearing from the public agency/school.

This means they can contest the agency/school's actions. Child care center staff needs to educate parents about their rights so that parents can be effective advocates for themselves and their children.

CONFIDENTIALITY

All families have a right to confidentiality. This means that information about child care children and families cannot be shared with outside agencies without parents' (or legal guardians') written permission. Information can only be shared within the agency on a "need-to-know" basis. Disclosure (talking about the personal lives of children and families) is unethical and illegal. Even if children's names are not used, any inappropriate discussion that makes children and families identifiable is a violation of privacy.

WHAT ARE THE RIGHTS AND PROTECTIONS GUARANTEED UNDER THESE LAW(S)?

NONDISCRIMINATION

Children ages 0 to 5 with disabilities have the right to:

- Comprehensive and nondiscriminatory testing and evaluation.
- Buildings and materials that are accessible.
- Support (aids, equipment, adaptations) that they need.
- Be considered for admission to the program – no matter what their disability.

All persons with disabilities have the right to:

- Equal employment opportunities.
- Access to all public accommodations and public transportation.
- Access to all public buildings. Physical barriers must be removed or alternatives must be offered.
- All state and local services and telecommunications.

CONFIDENTIALITY

Parents of children with disabilities have the right to:

- Confidentiality of records and conversations about their child's condition.
- Explanations of information and copies of records.
- Inspection and review of educational records.

INDIVIDUALIZED EDUCATION PLAN (IEP) OR INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP) AS A CONTRACT

Children ages 0 to 5 with disabilities have the right to:

- A free, appropriate, public education (FAPE) that provides special education and related services to meet their needs as specified in a written IEP or IFSP.
- Services without labeling: diagnosis must meet IDEA criteria, but states are not required to report children ages 0 to 5 by category of disability.
- An annual written IEP/IFSP designed to meet the child's needs.
- A coordinated, multi-agency approach to services.
- Variations in service delivery models.



Chapter 15 **Inclusion of Children with Disabilities**

LEAST RESTRICTIVE ENVIRONMENT (LRE)

Children ages 3 to 5 with disabilities have the right to:

- An education in an integrated setting with children without disabilities whenever possible and beneficial. This is called the least restrictive environment.

NATURAL ENVIRONMENT (NE)

Children ages 0 to 3 with disabilities have the right to:

- Receive early intervention services in natural environments including home and community settings in which children without disabilities participate to the maximum extent appropriate.

PARENTS AS CO-DECISION MAKERS

Parents of children with disabilities have the right to:

- Involvement in developing and approving all educational decisions about their child. The parent(s) signature(s) must be on the IEP/IFSP.
- Written notification of and participation in IEP/IFSP meetings.
- Due process: parents can contest the agency/school's actions.

** Adapted with permission from National Network of Resource Access Projects for Head Start. 1995. Child to Child: Maximizing Opportunities for Social Integration. Washington, D.C.: U.S. Department of Health and Human Services, Administration for Children, Youth and Families.*

The information listed on the charts that are following are: Adapted with permission from Adaptive Environments Center, Inc., and Barrier Free Environments, Inc., 1995. The Americans with Disabilities Act Checklist for Readily Achievable Barrier Removal 2.0. Boston, Mass.: Adaptive Environments Center, Inc. The checklist created by Adaptive Environments Center, Inc., was funded by a grant from the National Institute on Disability and Rehabilitation Research and reviewed for accuracy by the U.S. Department of Justice. However, this adaptation in Setting the Stage has not been reviewed by the Adaptive Environments Center for the U.S. Department of Justice. For further guidance on the Americans with Disabilities Act (ADA), contact the Southwest ADA Center, located in the 10 federal regions across the country at (800) 949-4232 (voice/TDD).

AMERICANS WITH DISABILITIES ACT (ADA) – BARRIERS CHECKLIST**PRIORITY 1: ACCESSIBLE ENTRANCE**

People with disabilities should be able to arrive on the site, approach the building and enter the building as freely as everyone else. At least one path of travel should be safe and accessible for everyone, including people with disabilities.

Path of Travel

QUESTIONS	YES	NO	POSSIBLE SOLUTIONS
Is there a path of travel that does not require the use of stairs?	–	–	<ul style="list-style-type: none"> • Add a ramp if the path of travel is interrupted by stairs. • Add an alternative pathway on level ground.
Is the path of travel stable, firm, and slip-resistant?	–	–	<ul style="list-style-type: none"> • Repair uneven paving. • Fill small bumps and breaks with beveled patches. • Replace gravel with a hard surface.
Is the path of travel at least 36 inches wide?	–	–	<ul style="list-style-type: none"> • Change or move landscaping, furnishing or other features that narrow the path of travel. • Widen the pathway.
Can all objects sticking out in the path be detected by a person with a visual disability using a cane*?	–	–	<ul style="list-style-type: none"> • Move or remove objects sticking out into the path. • Add a cane-detectable base that extends to the ground. • Place a cane-detectable object on the ground underneath as a warning barrier.
Do curbs on the pathways have curb cuts at drives, parking and drop-offs?	–	–	<ul style="list-style-type: none"> • Install curb cuts. • Add small ramps up to curbs.

*In order to be detected using a cane, an object must be within 27 inches of the ground. Objects hanging or mounted overhead must be higher than 80 inches to provide clear headroom. It is not necessary to remove objects that stick out less than 4 inches from the wall.



Chapter 15 **Inclusion of Children with Disabilities**

PRIORITY 2: ACCESS TO GOODS AND SERVICES

Ideally, the layout of the building should allow people with disabilities to obtain goods or services without special assistance. Where it is not possible to provide full accessibility, assistance or alternative services should be available upon request.

Horizontal Circulation

QUESTIONS	YES	NO	POSSIBLE SOLUTIONS
Does the accessible entrance provide direct access to the main floor, lobby or elevator?	—	—	<ul style="list-style-type: none">• Add ramps or lifts.• Make other entrance accessible.
Are all public spaces on an accessible path of travel?	—	—	<ul style="list-style-type: none">• Provide access to all public spaces along an accessible path of travel.
Is the accessible route to all public spaces at least 36 inches wide?	—	—	<ul style="list-style-type: none">• Move furnishings such as tables, chairs, display racks, vending machines and counters to make more room.
Is there a 5-foot circle or T-shaped space for a person using a wheelchair to reverse direction?	—	—	<ul style="list-style-type: none">• Rearrange furnishings, displays and equipment.

PRIORITY 3: USABILITY OF RESTROOMS

When restrooms are open to the public, they should be accessible to people with disabilities. Closing a restroom that is currently open to the public is not allowed.

Getting to the Restrooms

QUESTIONS	YES	NO	POSSIBLE SOLUTIONS
If restrooms are available to the public, is at least one rest room (either one for each sex, or unisex) fully accessible?	—	—	<ul style="list-style-type: none">• Reconfigure a restroom.• Combine restrooms to create one unisex, accessible restroom.

PRIORITY 4: ADDITIONAL ACCESS

When amenities such as public telephones and drinking fountains are provided to the general public, they should also be accessible to people with disabilities.

Drinking Fountains

QUESTIONS	YES	NO	POSSIBLE SOLUTIONS
Is there at least one fountain with clear floor space of at least 30 X 48 inches in front?	—	—	<ul style="list-style-type: none"> Clear more room by rearranging or removing furnishings.

WHY DOES INCLUSION SEEM MORE SUCCESSFUL IN SOME SITUATIONS THAN OTHERS?

While understanding these laws, regulations and underlying principles is important, more is required if the day-to-day inclusion of children with disabilities is to be successful. Our human temptation is to search for a formula or recipe for inclusion; knowing all the while that nothing of the sort exists. It is also our temptation to look outside ourselves and attribute success or failure to the student or to the severity of his/her disability.

Learning is a lifelong process; we must prepare all students individually to learn during and beyond school. Teachers can't do it alone. Special education staff can't do it alone. Parents can't do it alone.

Collaboration is essential. Collaborative teaming is the essential ingredient common to all situations where inclusion is a positive experience for all those involved, including students and staff.

Collaborative teaming is a group process that is committed to problem solving and action planning as follows:

- 1) Student-centered and family-focused
- 2) Transdisciplinary
- 3) Interdependent

Additional information on these defining characteristics follows.

CHARACTERISTICS OF COLLABORATIVE TEAMING**Student-centered and family-focused**

- Acceptance of inclusion
- "Whole child" approach to meaningful skills
- Recognition of family values, considerations and priorities

Chapter 15 **Inclusion of Children with Disabilities**

Transdisciplinary

- Everyone, regardless of position, is valued equally.
- Each individual's opinion and contribution is important.
- Everyone works together across traditional disciplinary boundaries.

Interdependent

- Decisions are made by consensus.
- Knowledge and skills from each team member are infused into the design of the student's program.
- "Role release" is common practice.
- Problems are solved collaboratively.
- Responsibility is shared.

Open, honest communication among team members develops with time and practice.

With the child and family as the central focus:

- Each and every team member should ask any questions they may have.
- Team members should offer suggestions when solutions are needed.
- Team members should ask for help when they feel overwhelmed.
- Team members should express any fears and frustrations they may feel.



ARKANSAS HEALTHY CHILDREN HANDBOOK

6TH EDITION • 2012

Chapter 16 Child Maltreatment

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**ARKANSAS DEPARTMENT OF
HUMAN SERVICES**



Division of Child Care and Early Childhood Education

Chapter 16 Child Maltreatment

In Arkansas, child care providers are required by law to report cases of known or suspected child maltreatment.

As a child care provider, you are often in a position to detect child maltreatment and help families get assistance for the problem. You also have a responsibility to make sure that child maltreatment does not occur in your child care setting.

ARKANSAS' CHILD ABUSE REPORTING STATUTE

*AR Code § 12-18-101 – 12-18-1108 is the code citation for the
CHILD MALTREATMENT REPORTING ACT.*

THE LAW STATES:

- You are required to report suspected or known maltreatment. It is not your role to have proof of maltreatment or to investigate the situation.
- If you have a reasonable cause to suspect that a child is being maltreated, and you report in good faith, you are immune to suit and to liability both civilly and criminally.
- No privilege or contract relieves anyone required by law to report suspected maltreatment.
- If you willfully fail to report suspected child maltreatment, you will be civilly and criminally liable for damages proximately caused by that failure.
- The identity of the person who made the report is not disclosed unless a court of jurisdiction orders release for good cause shown. Identity of the reporting source can be released to the prosecuting attorney or law enforcement upon request.

WHERE DO YOU REPORT SUSPECTED CHILD MALTREATMENT?

If you suspect child maltreatment or if you have any questions, call the Arkansas Child Abuse Reporting Hotline at 1-800-482-5964.

Mandated reporters may report nonemergency abuse or neglect by fax to 501-618-8952 using the fax form approved and distributed by the Arkansas State Police.

§ 12-18-402 (Mandated reporters) states:

When any of the following individuals has reasonable cause to suspect that a child has been subjected to child maltreatment or has died as a result of child maltreatment, or who observes a child being subjected to conditions or circumstances that would reasonably result in child maltreatment, he or she shall immediately notify the Child Abuse Hotline:

- 1) Any child care worker or foster care worker;
- 2) A coroner;
- 3) A day care center worker;
- 4) A dentist or a dental hygienist;
- 5) A domestic abuse advocate;
- 6) A domestic violence shelter employee;
- 7) A domestic violence shelter volunteer;
- 8) An employee of Department of Human Services;
- 9) An employee working under the contract for the Division of Youth Services of the Department of Human Services;
- 10) Any foster parent;
- 11) A judge;
- 12) A law enforcement official;
- 13) A licensed nurse;
- 14) Any medical personnel who may be engaged in the admission, examination, care or treatment of persons;
- 15) A mental health professional;
- 16) An osteopath;
- 17) A peace officer;
- 18) A physician;
- 19) A prosecuting attorney;

- 20) A resident intern;
- 21) A school counselor;
- 22) A school official;
- 23) A social worker;
- 24) A surgeon;
- 25) A teacher;
- 26) A court-appointed special advocate program staff member or volunteer;
- 27) A juvenile intake or probation officer;
- 28) A clergy member, which includes a minister, a priest, a rabbi and an accredited Christian Science practitioner, or other similar functionary of a religious organization, or an individual reasonably believed to be so by the person consulting him or her, except to the extent the clergy member:
 - A) Has acquired knowledge of suspected child maltreatment through communications required to be kept confidential pursuant to the religious discipline of the relevant denomination or faith; or
 - B) Received the knowledge of the suspected child maltreatment from the alleged offender in the context of a statement of admission;
- 29) An employee of a child advocacy center or a child safety center;
- 30) An attorney ad litem in the course of his or her duties as an attorney ad litem;
- 31) A) A sexual abuse advocate or sexual abuse volunteer who works with a victim of sexual abuse as an employee of a community-based victim service or mental health agency such as Safe Places, United Family Services or Centers for Youth and Families;
- B) A sexual abuse advocate or sexual abuse volunteer, including a paid or volunteer sexual abuse advocate who is based with a local law enforcement agency;
- 32) A) A child abuse advocate or child abuse volunteer, including who works with a child victim of abuse or maltreatment as an employee of a community-based victim service or a mental health agency such as Safe Places, United Family Services or Centers for Youth and Families;
- B) A child abuse advocate or child abuse volunteer including a paid or volunteer sexual abuse advocate who is based with a local law enforcement agency;
- 33) A rape crisis advocate or rape crisis volunteer;
- 34) A victim/witness coordinator; or

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- 35) A victim assistance professional or victim assistance volunteer;
- A) A privilege or contract shall not prevent a person from reporting child maltreatment when he or she is a mandated reporter and required to report under this section.
 - B) A school, Head Start program or day care facility shall not prohibit an employee or a volunteer from directly reporting child maltreatment to the Child Abuse Hotline.
 - C) A school, Head Start program or day care facility shall not require an employee or a volunteer to obtain permission or notify any person, including an employee or a supervisor, before reporting child maltreatment to the Child Abuse Hotline.

History: Acts 2009, No. 749, § 1; 2009, No. 1409, § 1.

HOW COMMON IS CHILD MALTREATMENT?

- During the fiscal year 2010, an estimated 3.3 million referrals, involving alleged maltreatment of approximately 5.9 million children, were made.*
- In Arkansas in 2010, 73,257 children were the subject of an investigation alleging child maltreatment (involving 45,872 referrals). Of these reports, the allegations related to 12,591 children were found true with a preponderance of evidence of maltreatment.*
- A report of child abuse is made every 10 seconds.**
- Child abuse occurs at every socioeconomic level, across ethnic and cultural lines, within all religions and at all levels of education.**
- More than five children die every day as a result of child abuse.***
- Younger children are more vulnerable to death as the result of child abuse and neglect.*
- In 2010 a nationally estimated 1,560 children died from abuse and neglect, with 79.4 percent of all child fatalities younger than 4 years of age.*
- It is estimated that between 50 and 60 percent of child fatalities due to maltreatment are not recorded as such on death certificates.****
- The estimated annual cost of child abuse and neglect in the United States for 2008 was \$124 billion.*****
- Child sexual abuse is seldom a one-time occurrence. Abusive relationships last an average of one to four years and many last much longer.*****

Notes:

* U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2011). *Child Maltreatment 2010*. Available from http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#can.

*** From Childhelp website: <http://www.childhelp.org/pages/about>. Childhelp is a leading national nonprofit organization dedicated to helping victims of child abuse and neglect. Childhelp's approach focuses on prevention, intervention and treatment.*

**** Info retrieved from: <http://www.gao.gov/new.items/d11599.pdf>*

***** U.S. Department of Health and Human Services Administration for Children and Families Administration on Children, Youth and Families Children's Bureau. Child Abuse and Neglect Fatalities 2009: Statistics and Interventions. Retrieved from <http://www.childwelfare.gov/pubs/factsheets/fatality.pdf>*

****** Fang, X.; Brown, D.S.; Florence, C.S.; Mercy, J.A. (2011, Sep 30). The Economic Burden of Child Maltreatment in the United States and the Implications for Prevention. National Center for Injury and Prevention Control, Centers for Disease Control and Prevention. Retrieved from: <http://www.cdc.gov/about/grand-rounds/archives/2011/pdfs/GRChld%20MaI FINAL16Jun2011.pdf>*

****** The National Committee for the Prevention of Child Abuse*

WHAT IS CHILD MALTREATMENT?

The National Committee for Prevention of Child Abuse (NCPA) defines child maltreatment as a nonaccidental injury or pattern of injury to a child. This may include nonaccidental physical abuse, neglect, sexual abuse and emotional abuse.

PANDA – PREVENT ABUSE AND NEGLECT THROUGH DENTAL AWARENESS

Almost three million children are reported as being abused or neglected each year in this country (NCCAN, 2006). By state law, dentists in every state are required to report suspected cases of child abuse and neglect to authorities. However, dentists make less than one percent of the reports (Mouden, 1994). This conflicts with data showing that 65 to 75 percent of cases of physical abuse involve injury to the head, neck and mouth (Becker, 1978; da Fonesca, 1992).

You have a chance to help spread the news about PANDA and to help prevent abuse and neglect. Please take a moment to see how you can become involved in a PANDA coalition in your state. Help dentistry make a difference in a child's life.

Educational Programs

The PANDA coalition offers a variety of educational opportunities aimed at providing information on the prevention of abuse and neglect of children, adults and the elderly. Although originally designed for dental audiences, the presentations can be tailored for a variety of groups, from lay persons to those with considerable background in health care or family violence.



Chapter 16 **Child Maltreatment**

The presentations focus on the role everyone has in decreasing the incidence of child abuse and neglect. Many people find family violence a difficult problem to confront. However, PANDA seminars will help them realize that their involvement in recognizing and reporting child abuse and neglect may not only save a child from further abuse, but it may also save a child's life.

The presentations include specific clinical aspects of child abuse and neglect recognizable in specific settings. State-specific statutory and liability aspects are also addressed. Individual state laws relating to violence reporting are discussed and health professionals are given guidelines to prevent exposure to liability. The seminars also cover preventing domestic violence and elder abuse and neglect.

While portions of the presentation may be uncomfortable for some individuals to view, the lecture is given in a positive light. The outcome is an increased awareness of the positive steps all citizens can take to stop abuse and neglect. The various presentations are suitable for all dentists, dental hygienists, dental assistants, physicians, nurses, child care workers, teachers and anyone who cares about preventing family violence.

For more information, contact the Office of Oral Health, Arkansas Department of Health, Little Rock, (501) 661-2595.

WHAT IS PHYSICAL ABUSE?

Physical abuse is nonaccidental injury inflicted upon a child that may include hitting, burning, biting, choking, etc.

SIGNS OF PHYSICAL ABUSE MAY INCLUDE:

- Child has unexplained or repeated injuries such as welts, bruises or burns.
- Child has injuries that seem to take the shape of an object (bruises look like the shape of a hand, belt buckle, electric cord; burns that are round, shaped like an iron or curling iron).
- Child has injuries that don't make sense for his/her age such as bruises on the legs or bottom of a child too young to walk or climb.
- Unlikely or different explanations of injury given by parent and/or child.

WHAT IS NEGLECT?

Neglect is failure to provide a child with the basic necessities of life such as supervision, food, clothing, shelter, education and medical care. Neglect also includes the failure or refusal to prevent abuse when it is known a child has been abused.

SIGNS OF NEGLECT MAY INCLUDE:

- Constant hunger
- Poor hygiene
- Inappropriate clothing
- Constant fatigue, listlessness
- Poor school attendance
- Health problems or lack of medical or dental care

WHAT IS EMOTIONAL ABUSE?

Emotional abuse is a pattern of behavior that injures a child's emotional development and sense of self-worth. Some examples are constant criticizing; insulting; rejecting and providing no love, support or guidance.

SIGNS OF EMOTIONAL ABUSE MAY INCLUDE:

- Regression in habit disorders such as thumb sucking, biting, rocking, bed wetting
- Behavioral extremes
- Poor peer relations
- Compulsiveness
- Obsessiveness
- Hysteria
- Phobias
- Hypochondria

WHAT IS SEXUAL ABUSE?

Sexual abuse is a sexual act between a child and an adult or older child for the sexual gratification of the adult or older child. It can be a physical or nonphysical act. Physical acts may include such things as touching a child's private parts, penetration of the child's vagina or rectum or oral sex. Nonphysical acts may include forcing a child to look at an adult's genitals, forcing a child to watch adults involved in sex, exposure of a child's genitals, talking to a child in a sexually explicit manner, exhibitionism or pornography.

SIGNS OF SEXUAL ABUSE MAY INCLUDE:

- Problems walking or sitting
- Bite marks
- Stained or bloody underpants
- Pain or itching in the genital or rectal area
- Bruising caused from restraints
- Soiling or wetting pants/bed
- Starting fires/stealing
- Eating disorders such as binge eating, bulimia or anorexia
- Depression/flat affect
- Withdrawn
- Knowledge of age inappropriate sexual information
- Excessive masturbation
- Child has problems sleeping (afraid to sleep alone, frequent nightmares, afraid to close eyes and afraid of darkness)

WHEN A CHILD DISCLOSES SEXUAL ABUSE

While children may disclose sexual abuse directly, often their disclosure is subtle or indirect, including:

- Hints or hidden disclosure, such as "My baby-sitter is bothering me," or "Aunt Sue wouldn't let me sleep last night," or "I don't like riding in the truck with Billy." The child may not have the vocabulary to specifically describe the abuse, may feel ashamed or may have promised not to tell. Gently encourage the child to tell you as much as he/she can. Remember that to make a report of suspected abuse, you do not need to know exactly what form the abuse has taken.

- Conditional disclosure, such as “You have to promise not to tell anyone.” The child may fear the consequences of disclosure. Often, the perpetrator has used threats to control the child. Assure the child that you want to help so the child and the perpetrator can get help. Tell the child that it was brave of them to tell and that something like that should not be a secret. Do not promise that you won’t report the abuse or promise anything else you cannot follow up on or control.
- Report information to Arkansas Child Abuse Reporting Hotline. Avoid having others question the child further. An Arkansas Department of Human Services – Division of Children and Family Services investigator **or** an Arkansas State Police – Crimes Against Children Division official should be the one to interview the child extensively in case the incident is referred for legal action and to prevent the child from feeling too much confusion from excessive questioning.
- Never make the child confront the accused adult. Depending on who the alleged perpetrator is, you may want to involve the parents in making the report with you. Other times you may decide to report without informing the parents.

(Note: A promise by another staff member (center director or supervisor) or parent to report does not relieve the child care worker of the duty to report.)

- Support a child that has disclosed sexual abuse by telling them you believe them and it is not their fault.

WHAT CAN YOU DO TO HELP CHILDREN WHO HAVE BEEN ABUSED?

Make them feel safe, loved and worthwhile. You can praise them, teach them how to cope with failure, protect them from violence and spend time with them.

WHO TO CONTACT FOR INFORMATION ABOUT CHILD ABUSE?

- Arkansas Child Abuse Reporting Hotline 1-800-482-5964
- Arkansas Commission for Rape, Domestic Violence and Child Abuse, Little Rock, 501-661-7975
- Arkansas State Police, Crimes Against Children Division, Little Rock, 501-618-8900
- PANDA, *Prevent Abuse and Neglect through Dental Awareness*, Office of Oral Health, Arkansas Department of Health, Little Rock, 501-661-2595



OTHER INFORMATION FOR CHILD CARE FACILITIES*

- Since child care providers are mandatory reporters of child abuse and neglect, they should be trained in compliance with Arkansas's child abuse reporting laws.
- Each facility should have a written policy for reporting child abuse and neglect where there is reasonable cause to believe that child maltreatment has occurred.
- The training should address physical, sexual and psychological or emotional abuse and neglect. Special training in child abuse and neglect may be offered related to children with disabilities.
- Training should be held for all staff to educate and establish child abuse and neglect prevention and recognition measures. This training may be extended to the children and parents/guardians with appropriate resources.
- Every staff person should be aware of what it is and how to report child maltreatment.
- Staff who report suspected abuse and neglect in the settings where they work should be immune from discharge, retaliation or other disciplinary action for that reason alone, unless it can be proven that the report was malicious.

*NOTE: *Information from "Caring for Our Children," 3rd Edition, 2011.*



ARKANSAS HEALTHY CHILDREN HANDBOOK

6TH EDITION • 2012

Chapter 17 **Promoting/Protecting Health of Child Care Providers**

Chapter Content

Preventing Infection
Precautions for Pregnant Providers
When Not to Come to Work
Stress
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Avoid Exposure to Toxic Chemicals



**ARKANSAS DEPARTMENT OF
HUMAN SERVICES**



Division of Child Care and Early Childhood Education

Chapter 17 Promoting/Protecting Health of Child Care Providers

A major health hazard for child care providers is caused by a tendency to ignore their own health needs in order to meet children's needs first. It is important to recognize that only when they care for themselves by keeping truly well and healthy can they provide the best care for children.

PREVENTING INFECTION

Infectious diseases are common in child care centers and homes. Most are not serious. However, since child care providers care for a number of young children, many of whom cannot control their secretions and have not yet learned principles of hygiene, there is the potential for spread of infections among provider children, children's families and into the community.

Therefore, it is important that the provider (child care center or home) be familiar with the infections common to child care and the measures to contain them.

Two important barriers that help prevent the spread of infection:

- **Immunization and appropriate hygiene practices.** Vaccines for measles, mumps, rubella, diphtheria, tetanus, pertussis (the adult Tdap vaccine), varicella (or clinician documented chicken pox) and polio are **strongly recommended** for providers. Vaccination for hepatitis B should also be considered. Also, an annual vaccine against the influenza virus is **strongly recommended**.
- **Hand washing.** Hand washing is the most important way to reduce the spread of infection. Careful hand washing should be done at the following times:
 - » Upon arrival for the day or when moving from one child care group to another.
 - » Before and after eating, handling food, feeding a child, giving medication or playing in water that is used by more than one person.
 - » After diapering; using the toilet; helping a child use a toilet; or handling any bodily fluid from sneezing; coughing or contact with sores (such as mucus, blood and vomit).
 - » After handling uncooked food (especially raw meat or poultry), handling pets or other animals, playing in sandboxes or handling the garbage.



PRECAUTIONS FOR PREGNANT PROVIDERS

Women of child-bearing age should be aware that unborn children can acquire several infectious diseases occurring in children in the child care setting. Such infections can cause miscarriage, birth defects or illness in the newborn. These infections include:

- Rubella
- Measles
- Mumps
- Cytomegalovirus (CMV)
- Herpes
- Hepatitis B
- Parvovirus B19
- Human Immunodeficiency Virus (HIV)
- Varicella (chicken pox)

Refer to “Preventing Communicable Diseases,” Chapter 11, for a detailed discussion of all of the above diseases. Routine immunization (or other proof of immunity) prior to pregnancy is strongly recommended for rubella, measles, mumps and hepatitis B. Screening for CMV and herpes is not routinely recommended for child care workers and no vaccine is currently available for either. Likewise, no vaccine is available for HIV or parvovirus B19, although screening tests may be performed prior to pregnancy.

Lacking proof of immunity for rubella, a pregnant woman should be referred to her obstetrician to be tested for rubella immunity. If not immune, she should not provide direct care for children who have rubella or are likely to get it. She will need to receive the rubella immunization after delivery.

A pregnant woman should be tested by her obstetrician for the hepatitis B virus. A pregnant woman who is not immune to hepatitis B should not be caring directly for children who have the disease or are likely to get it. She should discuss this situation with her prenatal care provider.

If a pregnant woman is concerned about HIV or parvovirus B10, she should discuss it with her doctor.

Influenza can also lead to very serious complications during pregnancy. Flu shots can safely be given to pregnant women and they should be encouraged to receive this vaccination.

Strict attention to hand washing and care with **ALL** children’s blood and secretions are the most effective safeguards for susceptible women against those infections for which there are no vaccines.

WHEN NOT TO COME TO WORK

Most people recognize that minor illness frequently occurs in the child care setting. It is expected that children will catch colds and flu. Adults working with young children are also likely to become ill. Yet, because of the difficulty of arranging for and keeping dependable substitutes, many center staff and home providers keep working when they are ill, convincing themselves that they really are not *“that sick.”*

Upgrading substitute coverage is critical to a well-run child care center or home even though creating a reliable substitute policy is a difficult task. Each situation with a sick person, child or adult, is unique. The best illness guideline to follow is this:

In centers, ask caregivers who cannot comfortably perform their daily activities to remain at home. Personnel policies should be written to allow and encourage caregivers to stay at home or deny care when they feel too sick to work.

Caregivers often work when sick because of fear of lost pay or feelings of guilt due to inadequate substitute coverage. All caregivers must make a choice that balances their personal concerns and those of the children. There are no absolute right or wrong decisions except in the rare cases of exposing children to serious contagious diseases.

Clearly, adults with serious illness such as meningitis or chicken pox should not be providing child care. Providers with other contagious diseases (e.g., strep throat, lice, impetigo) may return after treatment has begun. With mild diarrhea or herpetic cold sores, providers may work but must take extreme precautions in personal hygiene.

STRESS

Child care providers and parents have a very stressful vocation. Because caregivers have constant demands on their time, energy and adaptability, they are at risk for emotional and physical burnout. Adults working with children need to take responsibility for self-care measures by recognizing their own warning signals and planning daily stress reducers into their busy schedules.

SOME COMMON STRESS SYMPTOMS ARE:

- Frequent illnesses (colds, sore throats, etc.)
- Appetite and/or sleep disturbances (either a significant increase or decrease)
- Chronic fatigue and lack of energy even for fun activities
- Accident-prone behavior
- General irritability, difficulty relating to others, and easily angered
- Increased smoking, drinking or drug usage
- Diarrhea, indigestion, or stomach ailments

Chapter 17 Promoting/Protecting Health of Child Care Providers

- Increased muscular tension (headaches, neck aches or low back pain).
- Inability to concentrate or disorientation.

If ignored and allowed to become chronic, stress symptoms can affect areas of your life and lead to serious illness.

SUMMARY OF STRESS MANAGEMENT

- Learn to set goals and priorities.
- Manage time efficiently.
- Practice positive rules of good health.
- Deal effectively with your emotions.
- Harmonize your human relationships.
- Practice stress relievers and relaxation.
- Seek professional help for serious stress problems.
- Read books about stress or attend stress-management class.
- Work on communication and assertiveness skills.

STRESS RELIEF AND RELAXATION

PHYSICAL TECHNIQUES

- Practice deep breathing: breathe in relaxation; exhale stress.
- Take time for physical exercise: walk, run, dance, stretch or swim.
- Take a hot bath/shower.
- Get a massage.
- Soak feet in hot water and lemon.

DISTRACTING TECHNIQUES

- Listen to soft music.
- Daydream: use creative visualization or take a “mini” mind vacation.
- Read for pleasure.
- Sing out loud (in shower or in car).

INTERPERSONAL TECHNIQUES

- Spend daily self-time (minimum 15 minutes); e.g., polish nails or relax in hot tub.
- Schedule weekly “renewal time”, mark date and time on calendar and keep appointment with yourself. Go to library, museum, or window shopping.
- Spend time on a hobby.
- Buy yourself some flowers.
- Write in your diary.

SPIRITUAL TECHNIQUES

- Meditate
- Pray

Create a less stressful environment at home and at work by building a positive climate. Focus on “What’s good about today.” Discourage chronic complainers and critics by not listening and not accepting their dreary views.

WAYS TO PROMOTE GOOD STAFF HEALTH

- Provide a high counter with stools (or an adult-size table and chair) for staff who do clerical, administrative and curriculum work. Bring in adult-size folding chairs for staff meetings or place a phone book on a child-size chair to make it a more comfortable seat.
- Set aside private adult space and provide adequate backup to ensure a **genuine** break to alleviate stress.
- Train staff in proper techniques for lifting and bending to prevent leg and back strains. See *“BACK INJURY PREVENTION FOR CHILD CARE PROVIDERS”* later in this chapter for some guidelines on lifting and bending.
- Provide gloves for use when working with cleaning agents to help prevent skin irritation.
- Establish preventive health policies, which can reduce exposure to childhood illnesses and practice good preventive health procedures to help keep adults and children healthy.
- Include break and substitute plans in personnel policies.

SUBSTITUTES

- Consider joining with other centers to hire a sub that rotates between programs. This allows each center some guaranteed coverage and provides dependable employment for the sub. If nobody is absent on your scheduled day, the sub can supervise while regular staff attend to parent conferences, planning, etc.



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- Set a decent salary for substitutes.
- Regularly evaluate your center's substitute policy. Keep the sub list active; call subs periodically to make sure they are still available.
- Let parents know about the center's substitute procedures. They will appreciate your care and attention to staff illness.

BREAKS

Because of the cost of hiring additional staff, most centers must work with existing personnel during staff breaks. Use the following suggestions for coping with limited staff:

- Utilize administrative support staff to cover breaks. Some centers assign nonteaching staff to cover breaks on different days of the week.
- Integrate volunteers to cover breaks. Assign parents, students or community members as “floaters.” The key to making this plan work is regular scheduling and dependable volunteers!
- Be sure to give each volunteer a thorough orientation to the duties and responsibilities of a “floater.”
- If budget and staff-to-child ratio requirements allow, designate one staff member as a “floater” during break time for a week at a time.
- The “floater” should become familiar with each of the classrooms in a large center and also gain perspective on the program by changing roles.
- Overlap staff shifts. Some centers arrange for afternoon shifts to begin during the last half of the morning shift. Although more expensive, this model facilitates covering breaks and also allows teachers time to share concerns and communication regarding their program.
- Provide an inviting space for staff that encourages relaxation during breaks. Too often the staff lounge – if it exists at all – doubles as an office, a storage room and/or a place for a sick child. Even if space is limited, a comfortable chair placed in front of a window can serve as a place to relax. If at all possible, the center budget should pay for coffee, tea, juice or other refreshments for the staff to enjoy.

OTHER WAYS TO PREVENT ILLNESS AND INJURY FOR CHILD CARE PROVIDERS

Remember all those suggestions of *ways to prevent illness in child care settings* in Chapters 10 and 11? They will help you and your coworkers stay healthy. Your health is important so that you can provide the kind of care you want your children to receive.

IMMUNIZATIONS FOR CHILD CARE PROVIDERS

Safe vaccines are available against many diseases. No immunizations are required for child care providers. However, it is **strongly recommended** that all child care providers have immunity to the following diseases: diphtheria, tetanus, pertussis, measles, mumps, rubella, varicella and polio. Ideally, child care providers should also be immune to Hepatitis B.

NOTE: Child care providers who are **immuno-compromised** should not diaper children who recently received oral polio vaccine.

Immunity may come in the form of the person being exposed to the illness (natural immunity) or in the form of an immunization (active immunity). Adults need boosters of tetanus-diphtheria vaccine every 10 years, including at least one adult Tdap that also confers immunity to pertussis. Influenza (flu) vaccine given yearly is also highly advisable.

Adults born before 1957 are generally considered naturally immune to measles and usually do not need to be vaccinated. Adults born 1957 or after should check their health records to see if they were **both**:

- immunized in 1968 or later, **AND**
- immunized **TWICE** after their first birthday, at least 28 days apart, with live measles vaccine.

Additional vaccination(s) may be needed if all the above conditions are not met. On the other hand, vaccination would not be necessary for those who have had measles. If you are not sure if you have had measles or were vaccinated, there is no harm in a repeat vaccination.

Varicella (chicken pox) in adults is often particularly severe. Similar to measles, child care workers with no clear evidence of immunity to varicella should receive two doses of varicella vaccine at least 28 days apart. Those who have had typical chicken pox or shingles diagnosed by a health professional can be considered immune.

Note: Oral polio vaccine poses a risk for those whose immune systems are not fully working. Oral polio vaccine has not been routinely employed in the United States since 1999, but it is still used in many other countries (including Mexico and most of Africa, Asia and South America). **Child care providers who are known to be immune-compromised should not diaper children who recently received the oral polio vaccine within the past six weeks.**

BACK INJURY PREVENTION FOR CHILD CARE PROVIDERS

In order to work in a child care center/family home, an adult must be physically active. It's good for the children when their caregivers share their activities: playing with them, bending and getting down at their level, and holding or lifting them. Some of these activities may put stress on your back if not done correctly.

These guidelines are written to help you stay active while reducing the chances you will have any back problems.

Note: Being physically active is good for the back, as long as your activity is performed correctly, as these guidelines describe.

When you lift, bend or twist, use caution! These are the primary activities that can stress the back:

- To lift properly, keep the object (or child) close to your body. A way to remember to do this is to “hug your work!”
- When lifting, get close and bend at the waist more than you have to. Bending your knees can help reduce the stress on your back, but only if it helps you get the object close to your body's center of gravity (abdominal area). Also, do not twist your body – move your feet instead.
- Make sure you have a clear path and a good view of where you are going when you carry something. Get help if you have to move a large or heavy item.
- If you have an episode of back pain, make sure you follow the guidelines above to make sure you do not overstress your back while you are healing. If you have some back pain and want to take something for it, aspirin or aspirin substitutes should be sufficient; follow label instructions. Try ice packs or compresses over the painful area for 15 minutes, four times a day.
- Generally, bed rest is NOT recommended during back pain. Stay as active as you are able, but sit as little as possible and remember to follow the guidelines listed above.
- Be patient! You will get better. (If your doctor tells you to go to bed, talk to him/her about taking a 20-minute walk for every three hours of day-time bed rest to keep your muscles and bones from weakening from too much inactivity.)
- Lift only those items that must be lifted. Avoid lifting more than 30 pounds until your back pain subsides. Use good posture and “body mechanics.”
- Think of creative ways to avoid lifting. For example, instead of lifting children, have them step up to sinks or changing tables.

AVOID EXPOSURE TO TOXIC CHEMICALS

Art, craft and cleaning supplies may cause problems such as irritation to skin, nose, lungs or eyes. Be sure to read all instructions for using the supplies very carefully and follow all suggestions to prevent problems.

The following suggestions will help decrease this occupational hazard:

- Check the ingredients of paints, clays, cleaning supplies, etc., and use only nontoxic materials. Many items used in child care programs, even if listed as “nontoxic,” may have harmful effects on adults and children. Always maintain good ventilation and circulating air, and use gloves when working with dangerous or irritating substances.
- Check with the **Poison Control Center (1-800-3POISON)** or the manufacturer if you have questions about materials. The Arkansas Poison Control Center, housed in the UAMS College of Pharmacy, is part of a network of 70 poison control centers connected to a single 24-hour hotline telephone number: **1-800-222-1222**. **Providers or parents can also dial 1-800-3POISON for assistance.**
- If skin is irritated, protect it with gloves and/or moisturizing lotion.

PARENTAL DEPRESSION

Maternal depression affects millions of families in communities nationwide. As a response to this urgent public health problem, Project LAUNCH – Linking Actions for Unmet Needs in Children’s Health – has compiled a list of resources for the prevention and early intervention of parental depression. Head Start and Early Head Start health services, family services and education staff are encouraged to explore this list to find appropriate resources on depression to share with families and partners.

Parental Depression Resources

Websites and Materials on Parental Depression

Maternal Depression – *Making a Difference through Community Action: A Planning Guide* (in English and Spanish)

Mental Health – *The Head Start National Center on Health*

Family Connections Materials: *A Comprehensive Approach in Dealing with Parental Depression and Related Adversities*

The Mothers and Babies: *Mood and Health Research Program*

Center for Early Childhood Mental Health Consultation (CECMHC)

Facilitating Individualized Interventions to Address Challenging Behavior: Toolkit

Other Resources and Training Tools

Library: Resources and Training Tools – CECMHC

Text 4 Baby – Project LAUNCH

Reaching Out About Depression (ROAD)

The Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) and Title V Collaboration to Improve Child Health

Postpartum Support International (PSI)

Iowa’s 1st Five Healthy Mental Development Initiative

Appendix

Screening Tools and Approaches

Patient Health Questionnaire (PHQ)

Edinburgh Postnatal Depression Scale (EPDS) [PDF, 136KB]

Parenting Stress Index (PSI), 3rd Edition

Center for Epidemiologic Studies Depression Scale (CES-D), NIMH [PDF, 8.33KB]

Telemedicine

Brain Building in Progress Campaign (MA)

National Child Traumatic Stress Network (NCTSN)

Project LAUNCH – The Pew Center on the States

Parental Depression Resources. Project LAUNCH. English. 2011.

More on Parental Depression

Biting – A Fact Sheet for Families

Building Bridges Between Healthy Marriage, Responsible Fatherhood and Domestic Violence Programs

Family Connections Materials: A Comprehensive Approach in Dealing with Parental Depression and Related Adversities

Parental Depression Resources

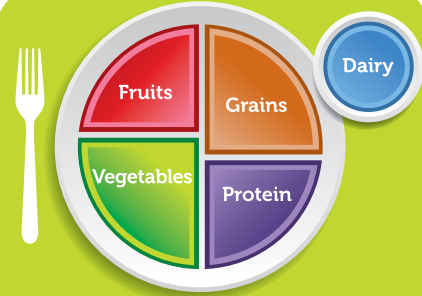
The Importance of Fathers in the Healthy Development of Children

Tips for Talking to Children After a Disaster

ChooseMyPlate.gov

MyPlate is part of a larger communications initiative based on *2010 Dietary Guidelines for Americans* to help consumers make better food choices.

MyPlate illustrates the five food groups using a familiar mealtime visual... a place setting.



The website features practical information and tips to help Americans build healthier diets.

Balancing Calories

- ### Foods to Increase

- ## Foods to Reduce

-

Appendix

CONSUMER RESOURCES

Let's Eat for the Health of It

The 2010 Dietary Guidelines brochure

This brochure contains practical strategies to make healthy food choices. The brochure highlights themes from the guidelines such as *Balancing Calories*, *Foods to Reduce* and *Foods to Increase*. This resource is available online as a PDF and print copies will be available in the near future.



10 TIPS SERIES

The 10 Tips Nutrition Education Series provides consumers and professionals with easy-to-follow tips in a convenient, printable format. Educators can use these to support existing lessons and consumers can choose one or more of these tips sheets to start making small changes toward healthier eating. These and many other printable items are available in Spanish.

- 1) Choose MyPlate
- 2) Add more vegetables to your day
- 3) Focus on fruits
- 4) Make half your grains whole
- 5) Got your dairy today?
- 6) With protein foods, variety is key
- 7) Build a healthy meal
- 8) Healthy eating for vegetarians
- 9) Smart shopping for veggies and fruits
- 10) Liven up your meal with vegetables and fruits
- 11) Kid-friendly veggies and fruits
- 12) Be a healthy role model for children
- 13) Cut back on your kid's sweet treats
- 14) Salt and sodium



ALSO ON THE WEB

- Sample menus for a week
- Food-group-based recipes
- Historical development of food guidance
- Nutrition communicators network for partners
- Application forms
- All print-ready content

Cucumber Yogurt Dip

Serving Size: 1/6 of recipe
Yield: 6 servings

Ingredients:

- 2 large cucumbers
- 2 cups plain yogurt, low-fat
- 1/6 cup sour cream, non-fat
- 1 tablespoon lemon juice
- 1 tablespoon fresh dill

Food Group Amounts:

Color	Food Group	Amount
	Grains	--
	Vegetables	1 1/2 c
	Fruits	--
	Dairy	3/4 c
	Protein	0

Nutrient Totals

Per Serving:

Calories	100
Total Fat	1.5 g
Saturated Fat	1 g
Total Protein	120 mg
Protein	6 g


Chill for 1 hour.

MYPLATE STYLE GUIDE

USDA encourages the use of the MyPlate icon in a variety of applications, including textbooks and other educational materials. Any educator or consumer interested in using the image should refer to this guide for all appropriate use information.

MyPlate

Style Guide and Conditions of Use for the Icon



Choose **MyPlate**.gov

USDA is an equal opportunity provider and employer.

USDA

July 2011

January 2012
Center for Nutrition
Policy and Promotion

**10
tips**
**Nutrition
Education Series**

choose MyPlate

10 tips to a great plate



Making food choices for a healthy lifestyle can be as simple as using these 10 Tips.

Use the ideas in this list to *balance your calories*, to choose foods to *eat more often*, and to cut back on foods to *eat less often*.

1 balance calories

Find out how many calories YOU need for a day as a first step in managing your weight. Go to www.ChooseMyPlate.gov to find your calorie level. Being physically active also helps you balance calories.

2 enjoy your food, but eat less

Take the time to fully enjoy your food as you eat it. Eating too fast or when your attention is elsewhere may lead to eating too many calories. Pay attention to hunger and fullness cues before, during, and after meals. Use them to recognize when to eat and when you've had enough.



3 avoid oversized portions

Use a smaller plate, bowl, and glass. Portion out foods before you eat. When eating out, choose a smaller size option, share a dish, or take home part of your meal.

4 foods to eat more often

Eat more vegetables, fruits, whole grains, and fat-free or 1% milk and dairy products. These foods have the nutrients you need for health—including potassium, calcium, vitamin D, and fiber. Make them the basis for meals and snacks.



5 make half your plate fruits and vegetables

Choose red, orange, and dark-green vegetables like tomatoes, sweet potatoes, and broccoli, along with other vegetables for your meals. Add fruit to meals as part of main or side dishes or as dessert.

6 switch to fat-free or low-fat (1%) milk

They have the same amount of calcium and other essential nutrients as whole milk, but fewer calories and less saturated fat.



7 make half your grains whole grains

To eat more whole grains, substitute a whole-grain product for a refined product—such as eating whole-wheat bread instead of white bread or brown rice instead of white rice.

8 foods to eat less often

Cut back on foods high in solid fats, added sugars, and salt. They include cakes, cookies, ice cream, candies, sweetened drinks, pizza, and fatty meats like ribs, sausages, bacon, and hot dogs. Use these foods as occasional treats, not everyday foods.

9 compare sodium in foods

Use the Nutrition Facts label to choose lower sodium versions of foods like soup, bread, and frozen meals. Select canned foods labeled “low sodium,” “reduced sodium,” or “no salt added.”



10 drink water instead of sugary drinks

Cut calories by drinking water or unsweetened beverages. Soda, energy drinks, and sports drinks are a major source of added sugar, and calories, in American diets.

A Parent's Guide to Safe Sleep

Helping you to reduce the risk of SIDS

DID YOU KNOW?

- About one in five sudden infant death syndrome (SIDS) deaths occur while an infant is in the care of someone other than a parent. Many of these deaths occur when babies who are used to sleeping on their backs at home are then placed to sleep on their tummies by another caregiver. We call this "unaccustomed tummy sleeping."
- Unaccustomed tummy sleeping increases the risk of SIDS. Babies who are used to sleeping on their backs and are placed to sleep on their tummies are 18 times more likely to die from SIDS.

You can reduce your baby's risk of dying from SIDS by talking to those who care for your baby, including child care providers, babysitters, family, and friends, about placing your baby to sleep on his back during naps and at night.

WHO IS AT RISK FOR SIDS?

- SIDS is the leading cause of death for infants between 1 month and 12 months of age.
- SIDS is most common among infants that are 1-4 months old. However, babies can die from SIDS until they are 1 year old.

KNOW THE TRUTH... SIDS IS NOT CAUSED BY:

- Immunizations
- Vomiting or choking

WHAT CAN I DO BEFORE MY BABY IS BORN TO REDUCE THE RISK OF SIDS?

Take care of yourself during pregnancy and after the birth of your baby. During pregnancy, before you even give birth, you can reduce the risk of your baby dying from SIDS! **Don't smoke or expose yourself to others' smoke while you are pregnant and after the baby is born. Alcohol and drug use can also increase your baby's risk for SIDS.** Be sure to visit a physician for regular prenatal checkups to reduce your risk of having a low birth weight or premature baby.

MORE WAYS TO PROTECT YOUR BABY

Do your best to follow the guidelines on these pages. This way, you will know that you are doing all that you can to keep your baby healthy and safe.

- Breastfeed your baby. Experts recommend that mothers feed their children human milk for as long and as much as possible, and for at least the first 6 months of life, if possible.
- It is important for your baby to be up to date on her immunizations and well-baby check-ups.

WHERE IS THE SAFEST PLACE FOR MY BABY TO SLEEP?

The safest place for your baby to sleep is in the room where you sleep, but not in your bed. Place the baby's crib or bassinet near your bed (within arm's reach). This makes it easier to breastfeed and to bond with your baby.

The crib or bassinet should be free from toys, soft bedding, blankets, and pillows. (See picture on next page.)

TALK ABOUT SAFE SLEEP PRACTICES WITH EVERYONE WHO CARES FOR YOUR BABY!

When looking for someone to take care of your baby, including a child care provider, a family member, or a friend, make sure that you talk with this person about safe sleep practices. Bring this fact sheet along to help, if needed. If a caregiver does not know the best safe sleep practices, respectfully try to teach the caregiver what you have learned about safe sleep practices and the importance of following these rules when caring for infants. Before leaving your baby with anyone, be sure that person agrees that the safe sleep practices explained in this brochure will be followed all of the time.

Supported in part by Grant No. U46MC04436-06-00, a cooperative agreement of the Office of Child Care and the Maternal and Child Health Bureau.



Appendix



Face up to wake up – healthy babies sleep safest on their backs.



Do not place pillows, quilts, toys, or anything in the crib.



Supervised, daily tummy time during play is important to baby's healthy development.

WHAT ELSE CAN I DO TO REDUCE MY BABY'S RISK?

Follow these easy and free steps to help you reduce your baby's risk of dying from SIDS.

SAFE SLEEP PRACTICES

- Always place babies to sleep on their backs during naps and at nighttime. Because babies sleeping on their sides are more likely to accidentally roll onto their stomach, the side position is just as dangerous as the stomach position.
- Avoid letting the baby get too hot. The baby could be too hot if you notice sweating, damp hair, flushed cheeks, heat rash, and rapid breathing. Dress the baby lightly for sleep. Set the room temperature in a range that is comfortable for a lightly clothed adult.
- Consider using a pacifier at nap time and bed time. The pacifier should not have cords or clips that might be a strangulation risk.

SAFE SLEEP ENVIRONMENT

- Place your baby on a firm mattress, covered by a fitted sheet that meets current safety standards. For more about crib safety standards, visit the Consumer Product Safety Commission's Web site at <http://www.cspc.gov>.
- Place the crib in an area that is always smoke free.
- Don't place babies to sleep on adult beds, chairs, sofas, waterbeds, pillows, or cushions.
- Toys and other soft bedding, including fluffy blankets, comforters, pillows, stuffed animals, bumper pads, and wedges should not be placed in the crib with the baby. Loose bedding, such as sheets and blankets, should not be used as these items can impair the infant's ability to breathe if they are close to his face. Sleep clothing, such as sleepers, sleep sacks, and wearable blankets are better alternatives to blankets.

IS IT EVER SAFE TO HAVE BABIES ON THEIR TUMMIES?

Yes! You should talk to your child care provider about making tummy time a part of your baby's daily activities. Your baby needs plenty of tummy time while supervised and awake to help build strong neck and shoulder muscles. Remember to make sure that your baby is having tummy time at home with you.

TUMMY TO PLAY AND BACK TO SLEEP

- Place babies to sleep on their backs to reduce the risk of SIDS. Side sleeping is not as safe as back sleeping and is not advised. Babies sleep comfortably on their backs, and no special equipment or extra money is needed.
- "Tummy time" is playtime when infants are awake and placed on their tummies while someone is watching them. Have tummy time to allow babies to develop normally.

WHAT CAN I DO TO HELP SPREAD THE WORD ABOUT BACK TO SLEEP?

- Be aware of safe sleep practices and how they can be made a part of our everyday lives.
- When shopping in stores with crib displays that show heavy quilts, pillows, and stuffed animals, talk to the manager about safe sleep, and ask them not to display cribs in this way.
- Monitor the media. When you see an ad or a picture in the paper that shows a baby sleeping on her tummy, write a letter to the editor.
- If you know teenagers who take care of babies, talk with them. They may need help with following the proper safe sleep practices.
- Set a good example – realize that you may not have slept on your back as a baby, but we now know that this is the safest way for babies to sleep. When placing babies to sleep, be sure to always place them on their backs.

If you have questions about safe sleep practices please contact Healthy Child Care America at the American Academy of Pediatrics at childcare@aap.org or 888/227-5409. Remember, if you have a question about the health and safety of your child, talk to your baby's doctor.

RESOURCES:

American Academy of Pediatrics
<http://www.aappolicy.org>
SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment
<http://aappolicy.aappublications.org/cgi/rep rint/pediatrics;128/5/e1341.pdf>

Healthy Child Care America
<http://www.healthychildcare.org>

National Resource Center for Health and Safety in Child Care and Early Education
<http://nrc.uchsc.edu>

Healthy Kids, Healthy Care: A Parent Friendly Tool on Health and Safety Issues in Child Care <http://www.healthykids.us>

National Institute for Child and Human Development Back to Sleep Campaign (Order free educational materials)
<http://www.nichd.nih.gov/sids/sids.cfm>

First Candle/SIDS Alliance
<http://www.firstcandle.org>

Association of SIDS and Infant Mortality Programs <http://www.asip1.org>

CJ Foundation for SIDS
<http://www.cjsids.com>

National SIDS and Infant Death Resource Center <http://www.sidscenter.org/>

The Juvenile Products Manufacturers Association <http://www.jpma.org/>

American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

Revised 2012

Recommended Immunization Schedule for Persons Aged 0 Through 6 years – United States, 2012

Vaccine ▼	Age ►	Birth	1 month	2 months	4 months	6 months	9 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years	
Hepatitis B ¹		Hep B	HepB			HepB								Range of recommended ages for all children
Rotavirus ²				RV	RV	RV ²								
Diphtheria, tetanus, pertussis ³				DTaP	DTaP	DTaP		see footnote ³	DTaP				DTaP	
<i>Haemophilus influenzae</i> type b ⁴				Hib	Hib	Hib ⁴		Hib						
Pneumococcal ⁵				PCV	PCV	PCV		PCV				PPSV		Range of recommended ages for certain high-risk groups
Inactivated poliovirus ⁶				IPV	IPV			IPV					IPV	
Influenza ⁷								Influenza (Yearly)						
Measles, mumps, rubella ⁸								MMR		see footnote ⁸			MMR	
Varicella ⁹								Varicella		see footnote ⁹			Varicella	Range of recommended ages for all children and certain high-risk groups
Hepatitis A ¹⁰								Dose 1 ¹⁰				HepA Series		
Meningococcal ¹¹								MCV4 — see footnote ¹¹						

This schedule includes recommendations in effect as of December 23, 2011. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at <http://www.cdc.gov/vaccines/pubs/acip-list.htm>. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (<http://www.vaers.hhs.gov>) or by telephone (800-822-7967).

1. Hepatitis B (HepB) vaccine. (Minimum age: birth)

At birth:

- Administer monovalent HepB vaccine to all newborns before hospital discharge.
- For infants born to hepatitis B surface antigen (HBsAg)-positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) 1 to 2 months after completion of at least 3 doses of the HepB series, at age 9 through 18 months (generally at the next well-child visit).
- If mother's HBsAg status is unknown, within 12 hours of birth administer HepB vaccine for infants weighing $\geq 2,000$ grams, and HepB vaccine plus HBIG for infants weighing $< 2,000$ grams. Determine mother's HBsAg status as soon as possible and, if she is HBsAg-positive, administer HBIG for infants weighing $\geq 2,000$ grams (no later than age 1 week).

Doses after the birth dose:

- The second dose should be administered at age 1 to 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks.
- Administration of a total of 4 doses of HepB vaccine is permissible when a combination vaccine containing HepB is administered after the birth dose.
- Infants who did not receive a birth dose should receive 3 doses of a HepB-containing vaccine starting as soon as feasible (Figure 3).
- The minimum interval between dose 1 and dose 2 is 4 weeks, and between dose 2 and 3 is 8 weeks. The final (third or fourth) dose in the HepB vaccine series should be administered no earlier than age 24 weeks and at least 16 weeks after the first dose.

2. Rotavirus (RV) vaccines. (Minimum age: 6 weeks for both RV-1 [Rotarix] and RV-5 [Rota Teq])

- The maximum age for the first dose in the series is 14 weeks, 6 days; and 8 months, 0 days for the final dose in the series. Vaccination should not be initiated for infants aged 15 weeks, 0 days or older.
- If RV-1 (Rotarix) is administered at ages 2 and 4 months, a dose at 6 months is not indicated.

3. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)

- The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.

4. *Haemophilus influenzae* type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)

- If PRP-OMP (PedvaxHIB or Comvax [HepB-Hib]) is administered at ages 2 and 4 months, a dose at age 6 months is not indicated.
- Hiberix should only be used for the booster (final) dose in children aged 12 months through 4 years.

5. Pneumococcal vaccines. (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPSV])

- Administer 1 dose of PCV to all healthy children aged 24 through 59 months who are not completely vaccinated for their age.
- For children who have received an age-appropriate series of 7-valent PCV (PCV7), a single supplemental dose of 13-valent PCV (PCV13) is recommended for:
 - All children aged 14 through 59 months
 - Children aged 60 through 71 months with underlying medical conditions.
- Administer PPSV at least 8 weeks after last dose of PCV to children aged 2 years or older with certain underlying medical conditions, including a cochlear implant. See *MMWR* 2010;59(No. RR-11), available at <http://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf>.

6. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)

- If 4 or more doses are administered before age 4 years, an additional dose should be administered at age 4 through 6 years.
- The final dose in the series should be administered on or after the fourth birthday and at least 6 months after the previous dose.

7. Influenza vaccines. (Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])

- For most healthy children aged 2 years and older, either LAIV or TIV may be used. However, LAIV should not be administered to some children, including 1) children with asthma, 2) children 2 through 4 years who had wheezing in the past 12 months, or 3) children who have any other underlying medical conditions that predispose them to influenza complications. For all other contraindications to use of LAIV, see *MMWR* 2010;59(No. RR-8), available at <http://www.cdc.gov/mmwr/pdf/rr/rr5908.pdf>.
- For children aged 6 months through 8 years:
 - For the 2011–12 season, administer 2 doses (separated by at least 4 weeks) to those who did not receive at least 1 dose of the 2010–11 vaccine. Those who received at least 1 dose of the 2010–11 vaccine require 1 dose for the 2011–12 season.
 - For the 2012–13 season, follow dosing guidelines in the 2012 ACIP influenza vaccine recommendations.

8. Measles, mumps, and rubella (MMR) vaccine. (Minimum age: 12 months)

- The second dose may be administered before age 4 years, provided at least 4 weeks have elapsed since the first dose.
- Administer MMR vaccine to infants aged 6 through 11 months who are traveling internationally. These children should be revaccinated with 2 doses of MMR vaccine, the first at ages 12 through 15 months and at least 4 weeks after the previous dose, and the second at ages 4 through 6 years.

9. Varicella (VAR) vaccine. (Minimum age: 12 months)

- The second dose may be administered before age 4 years, provided at least 3 months have elapsed since the first dose.
- For children aged 12 months through 12 years, the recommended minimum interval between doses is 3 months. However, if the second dose was administered at least 4 weeks after the first dose, it can be accepted as valid.

10. Hepatitis A (HepA) vaccine. (Minimum age: 12 months)

- Administer the second (final) dose 6 to 18 months after the first.
- Unvaccinated children 24 months and older at high risk should be vaccinated. See *MMWR* 2006;55(No. RR-7), available at <http://www.cdc.gov/mmwr/pdf/rr/rr5507.pdf>.
- A 2-dose HepA vaccine series is recommended for anyone aged 24 months and older, previously unvaccinated, for whom immunity against hepatitis A virus infection is desired.

11. Meningococcal conjugate vaccines, quadrivalent (MCV4). (Minimum age: 9 months for Menactra [MCV4-D], 2 years for Menveo [MCV4-CRM])

- For children aged 9 through 23 months 1) with persistent complement component deficiency; 2) who are residents of or travelers to countries with hyperendemic or epidemic disease; or 3) who are present during outbreaks caused by a vaccine serogroup, administer 2 primary doses of MCV4-D, ideally at ages 9 months and 12 months or at least 8 weeks apart.
- For children aged 24 months and older with 1) persistent complement component deficiency who have not been previously vaccinated; or 2) anatomic/functional asplenia, administer 2 primary doses of either MCV4 at least 8 weeks apart.
- For children with anatomic/functional asplenia, if MCV4-D (Menactra) is used, administer at a minimum age of 2 years and at least 4 weeks after completion of all PCV doses.
- See *MMWR* 2011;60:72–6, available at <http://www.cdc.gov/mmwr/pdf/wk/mm6003.pdf>, and Vaccines for Children Program resolution No. 6/11-1, available at <http://www.cdc.gov/vaccines/programs/vfc/downloads/resolutions/06-11mening-mcv.pdf>, and *MMWR* 2011;60:1391–2, available at <http://www.cdc.gov/mmwr/pdf/wk/mm6040.pdf>, for further guidance, including revaccination guidelines.

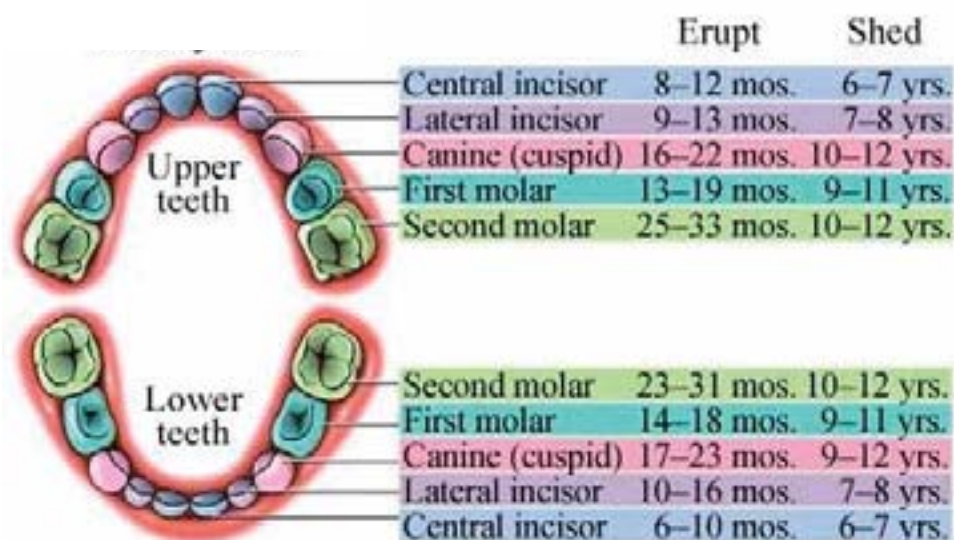
This schedule is approved by the Advisory Committee on Immunization Practices (<http://www.cdc.gov/vaccines/recs/acip>), the American Academy of Pediatrics (<http://www.aap.org>), and the American Academy of Family Physicians (<http://www.aafp.org>).
Department of Health and Human Services • Centers for Disease Control and Prevention



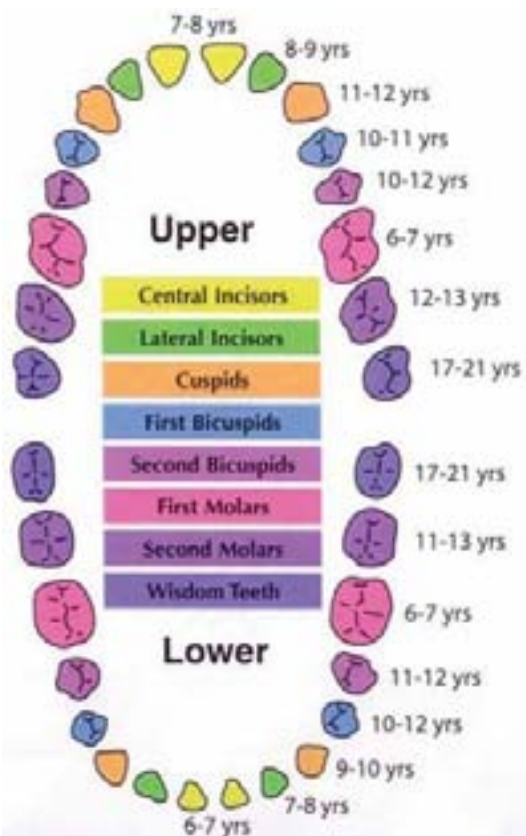
PRIMARY/PERMANENT TEETH ERUPTION CHART

Please note: When you look at the tooth chart, you are looking into a person's mouth with the jaws open. You're facing the person, so their upper right jaw will be on the left of this image.

Primary Teeth Eruption Chart



Permanent Teeth Eruption Chart





Remember to place this Poison Hotline number in your cell phone's speed dial and somewhere conveniently located so you can see it. The Arkansas Poison Center is available 24/7 and is staffed with licensed doctors, pharmacists and registered nurses. Whether someone has ingested an extra dose of medicine or swallowed a cleaning substance or you just have a poison question, feel free to call! You will speak to a live person in two rings or less each time! A caring voice on the other end of the line is always eager to help you through any poisoning situation, so remember to call if you need to.

